COMMUNITY BENEFITS "BEST PRACTICES"

A Compendium of Program Summaries
Submitted by Massachusetts Hospitals, HMOs
and Community Health Advocates

The Attorney General's Community Benefits Advisory Task Force

Scott Harshbarger
Attorney General

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Dear Friends and Colleagues:

An important mission of the Attorney General's Community Benefits Advisory Task Force is to encourage collaboration and sharing of information among organizations engaged in Community Benefits initiatives. In preparation for our recent conference "Good, Better, Best: Making the Most of Community Benefits," the Attorney General's Community Benefits Advisory Task Force invited each hospital and HMO and a variety of community organizations to submit summary descriptions of Community Benefit projects or initiatives that they believe represent "best practices."

What follows are all of the submissions received in response to this invitation, edited only for purposes of format. They offer a snapshot of some of the many Community Benefit initiatives taking place throughout Massachusetts through which hospitals and HMOs, in partnership with their communities, are helping to address the needs of medically-underserved populations.

These program summaries originally appeared in the materials distributed at our recent conference. We have reprinted these summaries as a free-standing document in response to requests we have received for more detailed information about the actual Community Benefits programs. I hope that this publication serves as a valuable resource for everyone involved in any part of the Community Benefits process.

Sincerely,

Scott Harshbarger

AHEC/Community Partners, the University of Massachusetts Medical Center

Healthy Communities Massachusetts

Goal: To increase community participation in the community benefits processes of hospitals and HMOs across the Commonwealth.

Target Population: Communities across the Commonwealth.

Description: For the past 2 ½ years, *Healthy Communities Massachusetts (HCM)* has worked to increase community participation in the hospital and HMO community benefit process in communities all across Massachusetts.

Healthy Communities Massachusetts established a task force composed of community groups engaged in the benefits process from across the Commonwealth. This task force met quarterly with members of the Office of the Attorney General and others to share the experiences of their communities and to learn from each other. The task force worked to increase the Attorney General's understanding of what was actually happening in the communities and the struggles they were experiencing engaging in the process. It also served to encourage widespread application of very specific tactics and techniques. For example: when other communities expressed interest, the task force shared a report card used on the Cape to assess their hospital's community benefit report.

HCM's task force also interacted with the Department of Public Health Prevention Centers and the Office of the Attorney General to ensure public access to hospital and HMO community benefits reports by placing them at Prevention Centers across the state. The goal was to increase opportunities for citizens to become involved in the community benefit process. Other related educational efforts included a training session in Western Massachusetts, a number of statewide workshops and the dissemination of written materials through the Healthy Communities newsletter and Health Care For All publications.

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The Allston-Brighton Healthy Boston Coalition

Leadership to Improve Neighborhood Communication & Services (LINCS)

Goal: To educate local providers about the health and social service needs and experiences of the various immigrant communities within Allston-Brighton, and, in turn, to educate members of these communities about the services available to them locally and how to achieve needed changes.

Target Population: Residents of Allston-Brighton, with an emphasis on newly settled (immigrant) and other members of the community for whom there may be significant barriers to health, education, housing, employment, or other human services.

Description: A comprehensive neighborhood assessment in the first year of the Coalition identified six main concerns:

- a severe shortage of adult education programming, especially ESL
- a shortage of visible leaders and organizations to organize and advocate for recently settled populations and racial minorities
- a lack of community cohesiveness, due to rapidly changing demographics
- inadequate access to health and social services, largely due to language and cultural barriers
- increasing crime
- few recreational and career mentoring programs targeted to older youth

LINCS was the Coalition's initial response to the findings of the community assessment. *LINCS* is an 8.5-month program that provides training in community organizing, leadership development, and English communication. *LINCS* helps previously isolated residents develop the skills, knowledge, and connections they need to become more self-sufficient. *LINCS* also supports local service providers by facilitating outreach projects through which trainees can undertake activities previously beyond the providers' scope. The *LINCS* curriculum features: a neighborhood survey incorporating questions from the mentor organizations; outreach projects based on survey results; a cultural conference; and independent projects. Since 1993, *LINCS* has trained 70 residents representing 23 countries and 19 native languages.

From September through June, 13 to 18 *LINCS* participants attend classes three nights a week to receive intensive training in public speaking, problem-solving, outreach, advocacy, cross-cultural communication, project evaluation, leadership development, team-building, and advanced English communication. Trainees earn a modest stipend for their work. In teams, *LINCS* participants work on real community projects with

mentors from local organizations interested in reaching out to isolated residents. They focus on such issues as women's health, childcare, domestic violence, mental health, and housing.

Through *LINCS*, trainees have reached thousands of local residents with vital health and human service information. Since 1993, *LINCS* participants have accomplished:

- the survey of over 1,250 residents, which required 15 languages, about issues of concern to community members
- the distribution of over 8,000 flyers in up to 6 languages providing vital information about 16 local health and human service organizations to the community
- the education of 2,000 residents by *LINCS* participants about available services; e.g., the Breast Health Team reached 400 individuals in the local Vietnamese and Latino communities to elicit their participation in a Breast Health Discussion
- via Cultural Conferences, instruction of over 250 health and human service providers about how to modify their outreach efforts and service provisions to better meet the needs of the local population. Conference topics have included a comparison of pregnancy, childbirth, and infant care traditions in the US with those of Peru, Macao, Iran, and the African American community, and an overview of housing needs of Russian, Central, and South American immigrants
- reaching over 1,500 individuals through independent projects implemented by trainees. Through independent projects, *LINCS* participants directly address an area of concern to themselves or their communities. For instance, three Russian-speaking trainees founded the Russian Social Club to provide an opportunity for elders to build relationships with one another

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Athol Memorial Hospital

Two-Part Series on Adolescent Health Issues

Goal: To inform parents and give them support and encouragement concerning the health and well-being of their children.

Target Population: Parents who are concerned about the physical and mental health of their teenage children.

Description: Athol Memorial Hospital sponsored a two-part series on adolescent health issues in the spring of 1998. The speakers were Anthony Wolf, PhD., author *of Get Out ofMy Life, But First Could You Drive Me and Cheryl to the Mall? A Guide to the New Teenager*, and Denise Paasche, MD, of North Quabbin Family Physicians. The Community Relations Department of Athol Memorial Hospital, a small community hospital in north central Massachusetts, coordinated the program. This event was part of an ongoing series of health and wellness programs sponsored by the hospital.

The program, free and open to the public, took place in a hospital-owned satellite, the West River Health Center, Orange. Dr. Wolf spoke about adolescent development on April 15, and Dr. Paasche gave a lecture entitled "Common Medical Issues for Adolescents: What Parents Can Do At Home" on May 4. In a community needs assessment, the hospital determined that parents were seeking help with teens. The hospital cooperated with Community Coalition for Teens, the North Quabbin Community Coalition, and Athol-Orange Community Television in creating the series. The talks were videotaped and broadcast numerous times over local cable access. Although the turnout for the talks was small, the total audience reached was much greater due to the repeated TV showings.

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Baystate Medical Center

(A member of Baystate Health System, Inc.)

Multifaceted Partnership with Springfield Public Schools

Goal: Improved health and well-being of children.

Target Population: School-aged children.

Description: A major focus of Baystate Health System's community health efforts over recent years has been the health and well-being of children. Working with the superintendent of the Springfield Public Schools, Baystate Medical Center (BMC) has developed an educational partnership that includes the following:

- Lincoln School Partnership: The relationship between Baystate Medical Center (BMC) and the Lincoln Magnet School of Discovery (an elementary school in Springfield) is the oldest, and best-established component of BMC's educational partnership. More than 18 departments at BMC have adopted classrooms at Lincoln School and the rooms are even named after the adoptive departments. BMC employees go to Lincoln to read to the kindergartners, serve as "Lunch Buddies" by sitting and talking with students at lunch time, and mentor individual students, helping them to build a positive outlook.

- School-to-Work Transition: BMC provides summer work opportunities as part of an annual program, which is a project of the School-To-Work Team of Communities (a federally-funded program of 42 local partnerships and Schools for Career Success). The program shares aspects of careers through an intensive series of workplace experiences, hands-on approaches to academic instruction, and a coordinated network of community and post-secondary programs. School-To-Work is an important element of economic development in the region which prepares and influences young people to fill a wide variety of jobs and influence their decision to remain in this area. In addition, there are opportunities for students to "shadow" BMC employees to obtain knowledge of what health positions involve.

- Curriculum Development: BMC staff serve as participating members of school-centered decision-making teams for several community schools. For example, BMC staff helped to create the curriculum for the High School of Commerce's new *High School of Health*, with the goal of inspiring interest in health care careers that may lead to further education and careers in health.

- Scholarships: The Baystate Neighborhood Scholarship Program, created in 1994, is another school-based program providing support to local students. Over the last four

years, BMC has provided economic assistance to 40 students pursuing college degrees in health-related fields with over $75,000 in renewable scholarships, summer employment and employee mentorships.

- School-based Care: BMC established health centers in 6 schools, where students can receive basic health care, including preschool physicals, immunizations, treatment of minor illnesses and health education. Gaining full Department of Public Health licensure for the centers as satellite sites of BMC has ensured staffing, programming, and clinical oversight of the services in these school-based health centers.

- Other: BMC has provided access to professional development training for Springfield school staff including a four day program for 75 teachers entitled "Medical Care Issues"; a program for 1,500 students on drinking and driving, and access to jobs for graduating students. In addition, BMC has donated items such as computers, furniture, educational materials, and office supplies to the schools.

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Berkshire Medical Center

Accent On Health

Goal: To offer programs that will enhance the health status of our employees and our community.

Target Population: General public of Central Berkshire County with special emphasis on youth and the uninsured.

Description: These resources will enable people to make informed decisions about their health care through the targeted use of health risk assessment tools, referral information, behavioral interventions, support groups and education. The use of interactive computerized medical information, brochures, videos, classes, discussions and individual counseling, provided in a professional setting of support and encouragement, will promote personal responsibility for health and improve health outcomes.

Berkshire Medical Center's Community Benefit Committee took into consideration numerous community surveys, and health status statistics from DPH and fashioned its own needs assessment tool that served as the basis for the *Accent on Health* initiative. The needs assessment process confirmed that there was a significant problem in the availability of information to the community regarding health care coverage and eligibility issues, information about prevention and wellness topics, and health resources in general.

A multi-focal approach was designed to meet the identified needs:

- In partnership with the local CHNA , and the DPH's Community Health Network, the hospital created a specialized outreach program to identify, support and track people eligible for MASS health coverage and other healthcare benefits.
- Every 2 weeks health education lectures are open to the community free of charge.
- A quarterly calendar is published to offer current, convenient information about health screenings, educational offerings and support groups.
- A telephone health-line was established to provide a centralized place for people to call to get answers to health-related questions.
- To reach those unable or unwilling to initiate participation, a van was purchased to enable registered nurses to deliver health information and free prevention/screenings out into the community.

Mobile components and services included:

- computerized health risk assessment
- various screenings including cholesterol and blood pressure checks
- counseling, education, answers to questions
- a video library with portable monitor
- a CD ROM with PC and printer
- information on insurance eligibility/health care coverage
- handouts and fact sheets

- access to medical residents from the hospital's teaching program

Community Collaboration is also encouraged. The partnership effort of the local CHNA is the work of collaboration with over 40 community agencies working together to enhance MASS Health sign-up efforts. Other examples of community collaboration include the regular bi-weekly visits of the van to the following agencies that serve the needy.

- Christian Center
- Salvation Army
- Mental Health and Substance Abuse Services of the Berkshires.

Agency representatives help coordinate the health education/screening efforts with their clients, and staff members reinforce new knowledge.

Since the Accent on Health program has been under way this year, over 20,000 health-related contacts have been made in the community. Over 80,000 free health calendars have been printed, over 20 lectures held and more than 500 people coached through the MASS Health sign-up process.

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Beth Israel Deaconess Medical Center/ Care Group

Building a Dialogue: The Latino Health Initiative

Goal: To enhance the health and well-being of the Latino community.

Target Population: Boston's Latino Community.

Description: The dramatic growth of Boston's Latino community in recent years has not only highlighted the strengths and vibrancy of this community but also brought to light a number of unmet health challenges and the importance of access to culturally competent care. In 1996, the Latino Health Institute, Beth Israel Deaconess Medical Center, and Harvard Pilgrim Health Care responded to these concerns by working with the community to address the health care needs of Latino families.

The first step was to develop a dialogue with the community and create an opportunity for residents, leaders, and service providers to identify key concerns. Throughout the winter and spring of 1997, we collaborated with organizations in seven neighborhoods— Allston-Brighton, Chelsea, Dorchester, Jamaica Plain, Mission Hill, Roxbury, and the South End— to conduct a health needs assessment of the Latino community. A related goal of this initial effort was to build relationships among institutions, organizations, agencies, and individuals to help ensure the success of future efforts to address the health care needs identified.

Our simple strategy -- to partner with a well-regarded and knowledgeable community-based organization -- was key to our success. Establishing trust with the Latino Health Institute, and subsequently with our other Latino partners, understanding how cultural orientation influenced our interactions and collaboration, and using this knowledge to craft an action agenda were significant steps in the project's successful implementation.

In June 1997, this collaboration started to find a voice. *Building a Dialogue: A Symposium on the Health Needs of the Latino Community* brought together more than 225 individuals to address the health and well-being of the Latino community. Included were representatives of the Latino community, community-based organizations, health care institutions, academic institutions, managed care/insurance companies, and government organizations. Based on the health needs assessment the symposium was organized as a forum to:

- disseminate the findings of the assessment, along with demographic information on Latinos and statistical data highlighting their health care needs
- advance dialogue among participants
- develop an action agenda based on a shared commitment to work together in meeting the Latino community's health needs

Presentations at the conference highlighted the significance of the growing Latino market for health care providers and insurers. It emphasized the necessity for community partnerships and cultural competence from institutions seeking to serve this market. Each

participant joined one of six work groups to develop solutions to meet the health care needs of the Latino community.

In April 1998, a report was issued which provided a summary of the primary health care needs identified through the neighborhood health needs assessment process, and a summary of symposium participants' recommendations for addressing those needs. The recommendations were grouped according to four key areas:

- Ensuring Access to Culturally Competent Health Care
- Enhancing Intervention and Care for Critical Health Needs
- Promoting Public Health
- Strengthening Advocacy

Implementation of recommendations requires a coordinated effort among numerous stakeholders, and demonstrates our mutual commitment to continuing the process of *Building a Dialogue*. Public/private partnerships, community collaborations, Latino participation in policy making, and organized political action also must be part of the solution. Joint initiatives have begun, but need to increase significantly in order to accomplish the tasks ahead.

Building a Dialogue provided Beth Israel Deaconess with the knowledge, relationships, and credibility to provide healthcare to the underserved Latino community. Most importantly, the initiative has resulted in new services including increased bilingual/bicultural primary care capacity, a new Latino mental health initiative, a Spanish Speaker's Bureau to provide community-based health education programs, and several programs to enhance the cultural competence of mainstream providers and institutions. *Building a Dialogue* provided a structure through which newly establishing relationships could grow and provided a forum for Latino voices to be heard and recognized.

Our partners in this venture included the Commonwealth's Office of Minority Health, and thirteen community-based organizations: Beth Israel-Deaconess Health Care/Jamaica Plain, Bowdoin Street Health Center, Centro Latino de Chelsea, Dimock Community Health Center, El Centro del Cardenal, Fenway Community Health Center, Hispanic Office of Planning and Evaluation, Joseph M. Smith Community Health Center, La Alianza Hispana, Medical Care Center North, Outer Cape Health Services, Sidney Borum Jr. Health Center, Sociedad Latina, Inc.

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Blue Cross and Blue Shield of Massachusetts

Jump Up and Go!

Goal: To help children, their parents and care givers as well as community leaders understand the direct link between physical activity and healthy, happy and productive children who will grow to become healthy adults.

Target Population: children across the Commonwealth

Description: Blue Cross and Blue Shield of Massachusetts and the American Heart Association – in conjunction with the Massachusetts Department of Public Health, the Department of Education, The Governor's Committee on Physical Fitness and the Northeastern University Center for Sport in Society – have joined forces to generate more awareness of the essential benefits of physical activity for families and children.

Studies by the U.S. Surgeon General and the Center for Disease Control found that there has been a decrease in the number of young people regularly participating in vigorous physical activity. The Massachusetts statistics mirror the national norm. This research led BCBSMA to develop the *Jump Up and Go!* initiative which focuses on the issue of children and physical activity.

Statewide community meetings to assess the physical activity needs of children in seven of the Commonwealth's cities and towns were held in Brockton, Chelsea, Framingham, Lawrence, Springfield and Worcester. Over 480 community leaders were invited and 64 actually attended. In these communities, the "Community Speakouts" provided the first opportunity for leaders to participate in a wide assessment and conversation about the issue of children and their need for physical activity.

These meetings also provided Blue Cross and Blue Shield with an opportunity to develop relationships with local leaders and to understand the dynamics and needs in each of these communities. Initially, we requested mailing lists from known community groups and invited hundreds of individuals. However, this was not as effective as when the community leaders personally invited others to join them for the meeting. The well-attended meetings hosted by established organizations such as the Greater Worcester Community Foundation, the Springfield Partners for Healthy Communities, the Brockton Mayor's Advisory Council, and Chelsea's ROCA are examples of this trend.

In Boston, the Community Relations Director attended a meeting of the Boston Youth Sports Conference, which had already become the measuring stick of physical activity needs of children in the city of Boston.

Information garnered from these sources helped to develop the *Jump Up and Go!* initiative and Guidelines for the Grantmaking component of the Community Benefits Plan.

Measurable Outcomes:

- Grants totaling $75,000 were awarded to 15 community-based groups which serve approximately 1,900 underserved children

- A $25,000 Grant was awarded to The Northeastern Center of Sport in Society's Urban Youth Programs

- $50,000 for Healthy Choices, a Department of Public Health and Department of Education Middle School Physical Activity and Nutrition Program, is in development with plans for implementation in the 1999-2000 school year

- A *Jump Up and Go!* Activity Month is in development and planned for May of 1999

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Brigham and Women's Hospital, Children's Hospital, *and* Faulkner Hospital

Jamaica Plain Asthma/Environmental Project

Goal: To identify school children with asthma, increase their understanding of how to manage the affliction, identify and address asthma-related environmental issues in the schools and households of JP children, increase access to quality health care for treatment, and increase awareness of asthma as a community health problem.

Target Population: school children of Jamaica Plain attending JP elementary schools, parents and other household members with asthma, teachers in JP elementary schools, and health care providers serving JP residents.

Description: Brigham and Women's Hospital, Children's Hospital, and Faulkner Hospital coordinated with community residents, the Jamaica Plain Tree of Life, and the Jamaica Plain Community Benefits Group over a two year period to develop an initiative to address asthma issues in Jamaica Plain (JP), with a focus on afflicted children. This spring the group developed a final proposal and received funding from all three hospitals.

Asthma and environmental issues were identified as a health priority in several ways. In two speak outs held in the JP community, residents expressed their concern about asthma among school age children and their understanding of the relationship between environmental factors and high rates of asthma. Data from the Health of Boston report by the Boston Public Health Commission also demonstrated that school children in JP have higher rates of asthma than children state wide. Furthermore data from the Emergency Medical Service of Boston showed JP has one of the highest rates of calls to 911 for asthma. JP school nurses indicated a need for assistance with educating students, teachers and parents about asthma.

Residents of JP formed coalitions through the JP Tree of Life and the JP Community Benefits Group to present to hospitals their health concerns and priorities. Representatives from both of these groups formed a working committee with representatives from the hospitals to develop this project. The structure of the project and the interventions were decided upon in this process. An Advisory Committee provided the oversight of the project with representation from community residents and parents of JP school children. Other members of the advisory committee included a hospital representative, representatives from community organizations, and from the JP schools administration and nurse staff.

The project has four major interventions:

- Asthma Education and Monitoring among School Children: Working with the school nurses, program staff will identify children with asthma in each of the elementary public schools in JP. A bilingual asthma educator will educate children about the underlying process of asthma as an illness, the signs and symptoms of asthma, their role in managing asthma, and factors that trigger asthma.
- School-based Environmental Assessment: The Environmental Protection Agency has developed programs to encourage schools to participate in efforts to improve indoor air quality using the *Tools for Schools* environmental assessment and action tool. A team of parents, teachers, school health personnel, school administrators and project staff will identify environmental triggers and methods for correcting them. MassCOSH will develop educational sessions to train team members about asthma and school environmental factors contributing to asthma. The team will subsequently survey the school and identify 2-3 areas that are amenable to correction. The team will facilitate the process and help identify ways to overcome barriers to correcting the environmental issues identified for improvement.
- Home Environment and Family Assessment: The Project Coordinator will offer the parent/guardian of children with asthma a home visit or an interview. These will be conducted by Home Visitors who are trained to complete a standardized questionnaire to assess the home for asthma triggers, identify other members of the household with asthma, and determine access to health care. City Life/Vida Urbana, a JP housing organization will provide advocacy for improved housing.
- Health Care Access and Asthma Care: Project staff will identify the health care providers for children and members of their household identified with asthma. Asthmatics and other family members without a primary care provider or usual source of health care will be referred to one of the three health centers or one of the hospitals in JP. Health centers will be asked to participate in the asthma management component of this project. With clinicians from BWH and Children's Hospital, the project staff will work with primary care providers to upgrade asthma protocols and guidelines, especially for moderate to severe asthma.

We anticipate that this effort will increase understanding of asthma and the management of asthma among school aged children in JP. School staff and administrators will learn about environmental factors and identify correctable "asthmagens". A better understanding of the contributing home environmental factors and how to treat these factors to improve housing will develop. We anticipate that children and adults with asthma will have improved access to quality asthma care. Providers in the community will gain a better understanding of the environmental issues contributing to their patients' asthma.

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Brightside for Families and Children

(A Member of the Sisters of Providence Health System)

Across Ages

Goal: To educate students about the dangers of alcohol, tobacco and drug use; strengthen their academic skills, decrease absenteeism and improve their in-school behavior; enhance their problem-solving, coping and decision-making skills; increase their feelings of self worth, and their ability to form significant relationships with older adults.

Target Population: 6th-grade youth in three Springfield public middle schools - Brookings, Chestnut and Forest Park - identified as "at-risk" communities for alcohol, tobacco and drug use.

Description: Funded by the federal Center for Substance Abuse Prevention, *Across Ages* is a partnership among Brightside, the Springfield Public Schools and the University of Massachusetts Center for Survey Research. Additional partners include several nursing home organizations in the greater Springfield area: Ring/Ridgewood, Mason Wright Manor and Reeds Landing in Springfield, Country Estates and Genesis Elder Care Heritage Halls North, South, East, and West in Agawam, and the Center for Rehabilitation and Nursing Care in West Springfield.

Brightside staff members, classroom teachers and nursing home activity directors worked together to develop *Across Ages* as a replication of a federal grant program operated successfully by Temple University in Philadelphia. The four interventions of the *Across Ages* project are:

- Matching older adult (55+) mentors with youth;
- Engaging youth in community service with nursing home residents;
- Providing a classroom-based positive youth development curriculum; and
- Involving parents in activities and workshops.

The project served a minimum of 155 students per year for three years.

Students took pre- and post-tests based on the program components. While the final evaluation report will not be completed until later this fall, preliminary findings indicate that students demonstrated:

- improved knowledge about and reactions to drug use
- improved attitudes toward adults and the elderly in particular
- improved school attendance and reduced disruptive behavior in the classroom
- greater ability to solve problems; and increased decision-making and coping skills.

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Brockton Interfaith Community

Brockton Interfaith Community Health Care Campaign

Goal: To improve the health of Brockton area residents and to increase communication between Brockton's two hospitals, Good Samaritan Medical Center and Brockton Hospital, and their constituents.

Target Population: Brockton area residents

Description: The Brockton Interfaith Community (BIC), a coalition of 16 religious congregations representing 5,000 families, is a broad based power organization, rooted in faith values, working to make concrete improvements in the lives of families, congregations, and the city of Brockton. By identifying, training, and developing leaders, and by organizing around winnable issues, BIC enables people to understand their power and gives them the skills and allies necessary to use that power effectively. Since 1990, BIC has won major victories around home ownership and neighborhood stabilization, youth programming, after school programs, public safety, and health care.

BIC does needs assessments through outreach involving its 5,000 families. In 1997, BIC held house meetings and hundreds of one-on-one conversations within its collective congregation to find out which health issues were most pressing to its communities. It was out of these discussions that the issues arose. BIC began its health care campaign, dedicated to:

- identifying pressing needs faced by members of BIC member congregations
- researching health care to develop proposals to address the issues
- negotiating with the CEOs of the two local hospitals
- unveiling the agreements at a public meeting of 600 Brockton residents on May 28, 1998.

We anticipate this campaign will lead to new initiatives with additional health care institutions in the years to come

BIC identified two major health issues for negotiation with the hospitals:

- the number of people unable to afford their prescription medications
- the number of uninsured people in Brockton

BIC leaders have heard countless stories from people who cannot afford their medications, or who have reached the caps in their programs, or who skip payments for rent, food, and utilities in order to buy their medications. The result is that people get sicker and, in the long run, need even more money. In response, BIC negotiated an agreement with Good Samaritan Medical Center, which has agreed to fund a pilot project at the Brockton Neighborhood Health Center.

The project will take advantage of Section 602, which allows federally licensed health centers to purchase medications at a major discount through off-site pharmacies. By working with the Plaza Pharmacy across the street, the health center will obtain medications at a discount significant enough that they can provide to uninsured or underinsured patients. BIC found that Brockton Hospital provides medications to outpatients who state that they cannot

afford them, but that many leave the hospital unaware of this option and refrain from using medications at all. BIC negotiated an agreement with Brockton Hospital to notify all patients about this program and to increase the budget for free medications to meet the increased demand that would logically ensue.

Health insurance: BIC research shows that Brockton may have as many as 22,000 inhabitants without health insurance, a high percentage of whom are now eligible for MassHealth. Good Samaritan and Brockton Hospital have worked to sign people up for MassHealth, but BIC's outreach into the community identified two shortcomings. First, many of the Mass Health workers were not trained in the community health outreach skills necessary to break through the barriers and sign people up for insurance. Second, hospitals were meeting with civic and parent associations, groups whose members most likely already knew which programs they could access, but were missing those people most in need of MassHealth: the isolated people who would not be reached by traditional outreach. Both hospitals agreed to put sufficient funds in their outreach budgets to send outreach staff door-to-door in streets and neighborhoods identified by BIC and other groups, to sign the hard to reach people up for MassHealth. Good Samaritan, which had not yet used the Community Health Education Center, agreed to certify its staff as community health outreach workers.

What makes this initiative so exciting is that the hospitals were not left to attempt to anticipate the community's needs or do assessments based on limited reach – a community organization representing 5,000 families approached the hospitals requesting collaboration. Through every step of this process, the community took the lead. In response, the hospitals have shown their good faith commitment to not just serving the community, but also working with the community. The result is a stronger dialogue and partnership between the community and its two hospitals and thousands of people who will be able to obtain their prescription drugs or sign up for MassHealth who would not have been able to otherwise.

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Caritas Christi Health Care System

Fishing Partnership Health Plan

Goal: The Fishing Partnership Health Plan (FPHP) was developed in collaboration among Caritas Christi Health Care System, the Massachusetts Fishermen's Partnership (MFP) and Tufts Health Plan (THP) designed to provide access to affordable, stable, and high-quality health care coverage for individuals and families in the New England fishing community.

Target Population: Underserved families and individuals of the New England fishing community.

Description: Even in the best of times, the fishing industry is characterized by seasonal fluctuations in employment, self-employment, part-time work and service contracting. Decline in income, coupled with the increased cost of health care, and the complex and changing nature of eligibility for public programs has led to a high proportion of the industry being without health insurance. In 1996, Caritas Christi commissioned a survey of the Massachusetts fishing communities which revealed that 43% of the community suffered without health care coverage, (approximately three times the state average). Lack of insurance can cause great hardship and even help force already financially stressed fishing families out of the industry. Finally, because families in the fishing industry are concentrated around working ports, this lack of health insurance coverage severely stresses the health delivery systems in these communities.

Recognizing the communities' need, Caritas Christi and Tufts Health Plan provided administrative and financial support for the development of the FPHP. In addition, Caritas Christi helped to secure $1.95 million from the Department of Commerce, and $2 million per year for five years from the Massachusetts Uncompensated Care Pool to subsidize the health plan. As a result, the FPHP is able to partner with Tufts Health Plan to offer comprehensive HMO coverage, and access to the entire Tufts Health Plan provider network, to the fishing communities while charging premiums that are an average of 40% below market prices.

The Massachusetts Fishermen's Partnership (MFP) has collaborated very closely with Caritas Christi Health Care System (Caritas Christi), Fishing Partnership Health Plan (FPHP) and Tufts Health Plan (Tufts) to enroll fishing families in this new health plan. In the first eight months of operation, the FPHP is showing clear signs of success. With 659 subscribers, the program serves more than 1300 members. The members are geographically distributed throughout coastal Massachusetts with 33% residing in the Gloucester area, 31% in Boston and New Bedford, and 28% on Cape Cod and the Islands. In addition, the FPHP is currently operating in New Hampshire and plans to expand into Rhode Island and Maine.

FPHP utilization data are maturing and remain encouraging. The top in-patient diagnostic category is pregnancy, childbirth, and related complications. The top two outpatient diagnostic categories are routine medical exams and routine child health exams. Finally, the Account Cost Per Member per Month (PMPM) is promising: the total Account Cost PMPM is 16% less than the Tufts Health Plan's network average.

This progress is remarkable considering the state of Massachusetts' fishing communities. The fishing industry is one of the oldest business sectors in the country. The industry relies on the participation of a diverse labor force in communities that are often heavily dependent on fishing and related employment. In recent years, Federal regulations have been imposed to limit the number of days and geographic areas that the fishermen can legally fish. The industry's adjustment to the Federal regulation and declining stocks is causing economic stress and dislocation among fishing families.

Reaching the fishing industry presents a challenge due to the lack of a traditional employer/employee relationship. To overcome this obstacle, the FPHP, with significant financial support from Tufts Health Plan, contracts with the Massachusetts Fisherman's Partnership (MFP) to provide outreach centers in the fishing communities of Gloucester, New Bedford, and Hyannis.

Outreach to the fishing community has included distribution of enrollment kits and FPHP information along wharves, in fish houses and during industry meetings, as well as through application enrollment assistance. Robert Noonan, a Gloucester fisherman, said that he was skeptical at first. "When I left the office to take the kit home to study, I was sure I wouldn't be back, but now that I have had the chance to look into the plan, it is a wonderful thing that the Partnership has done for fishermen." Noonan didn't have health insurance before, but he was able to enroll in the Fishing Partnership Health Plan and get full coverage for the first time. Many fishermen enrolling in the plan were previously paying higher premiums for coverage with large deductibles. Tom Traina, a Chatham fisherman, said that the Fishing Partnership Health Plan is cheaper than the small business group plan he was using before, saying "this plan finally gives me good coverage and saves me money at the same time." This is very important for the fishing community during the present period of heavy restrictions on fishing while incomes are falling dramatically to allow fish stocks to rebuild. Terry Picard, a Chatham fisherman, said, "I have never had health coverage for my wife and two children, and that's a big risk. This is an affordable plan for a fishing family."

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Children's Hospital

Injury Prevention Program

Goal: To reduce the number of unintentional injuries to Boston children through the promotion of prevention activities including outreach, safety education and product distribution.

Target Population: Children ages 1-12

Description: Since 1996 the *Injury Prevention Program* has affected more than 3,500 children living in Boston. Data from our annual community needs assessment revealed that unintentional injuries were the leading cause of death and disability to children ages 1 to 19 years. Children residing in the city of Boston have higher rates of injury compared with children in Massachusetts as a whole. Recognizing that unintentional injuries are the single greatest health threat facing children, a subcommittee of the Community Benefits Advisory Board was created to address this issue. The subcommittee consists of staff from Children's Hospital and Martha Eliot Health Center, representatives from the Boston Public Health Commission Childhood Injury Prevention Program, health centers, tenants' organizations, and other community-based organizations and grass-roots agencies.

Currently, the program has three initiatives:

- Car Seat Program: Children's Hospital partnered with the Boston Public Health Commission Childhood Injury Prevention Program as one of the originating members of *Buckle Up Boston!* This program distributes car seats to income-eligible families residing in Boston. Each family that receives a car seat is required to attend a two-hour training on proper car seat use at Children's Hospital. Additionally, the Injury Prevention Program has a train-the-trainer educational series where community-based employees and hospital staff statewide are trained to instruct families on correct car seat installation.

- Window Guard Program: Children's Hospital works collaboratively with Boston Public Health Commission Childhood Injury Prevention Program and Boston Building Materials Co-op, Inc. (BBMC) to distribute window guards to low and moderate income landlords of 1 to 3 unit dwellings in Boston. In collaboration with citywide efforts, this program requires that landlords attend a training program at BBMC prior to receiving the window guards. Installation is provided for participants unable to install the product.

- Public Education Program: This program combines product distribution with public education. Quarterly themes are followed and educational materials are distributed along with a safety product. Between June and August, 1998 Children's Hospital worked collaboratively with Bikes Not Bombs and the Boston Housing

Authority's Safety Division to distribute over 2,000 multi-sport helmets. The helmets were distributed at Children's Hospital, Martha Eliot Health Center and four public housing sites. Staff and trained individuals from the community fitted the helmets on children and provided education about the importance of wearing a helmet.

Each initiative in the *Injury Prevention Program* is evaluated to assess the effect of the program on the target population and to identify areas for improvement. Data is collected to assess rates of use, recipients experience with the program, and educational component of the program. Car seats, window guards and sport helmets have been shown to effectively prevent serious injury to children. It is anticipated that the initiatives will increase:

- the rate of car seat use among children traveling in cars (including taxis)
- the number of homes with young children who have window guards installed
- the rate of helmet use among patients who bicycle, rollerblade, or skateboard.

Written and telephone surveys of individuals who receive products and observations in the target neighborhoods are utilized to collect data for the evaluations of these programs

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Community Health Center of Franklin County *and the* Franklin Medical Center

Health Links

Goal: To provide a comprehensive system of dignified, high quality medical care regardless of patients' insurance status or ability to pay.

Target population: Medically uninsured and underinsured population residing in Franklin County and the North Quabbin region

Description: *Health Links* has evolved into the Franklin County community's response to the problem of increasing numbers of our people lacking medical insurance.

This program was originally designed to provide access to free, urgent medical care for uninsured and underinsured working and low-income Franklin County residents. It was initiated in 1993 by a small, ad hoc group of hospital and human service workers. Beset by increasing numbers of their clients being unable to gain access to the most basic needed care, they negotiated informal arrangements with local physicians to send patients for free care.

Prior to the existence of the *Health Links* program, the community hospital's emergency department had been the only point of access to medical care for uninsured or underinsured Franklin County residents. The hospital had never been an outpatient primary care provider, nor had there ever been a federally qualified or federally funded community health center serving this, the most sparsely populated county in the Commonwealth. Thus, apart from federally funded family planning and other similarly narrowly focused clinical public health services, the *Health Links* program represented the first time in this community's life that routine medical care was offered to the population on a non-commodified basis.

Franklin Medical Center sought and received federal funding for *Health Links* from the Rural Health Outreach Program for the period 1994-97, enabling it to hire staff to coordinate the activities of volunteer nurses, providers and lay health advocates, and to provide referrals and direct case management support to clients. Beginning in 1995, *Health Links* staff also carried out consistent data collection activities.

At the termination of the federal rural health outreach grant, Baystate Health System (the parent corporation of Franklin Medical Center) continued to support the hospital's participation in *Health Links*, including maintaining its contribution of free diagnostic services (lab, x-ray and other hospital-based diagnostics) for Health Links patients.

The Community Health Center of Franklin County received its designation as a new federally funded health center and began seeing patients in December 1997. At this time all *Health Links* patients were "dually enrolled" for the health center, adding the option of continuous comprehensive primary care to the previous approach, which had been primarily to take care of urgent medical problems. With the addition of the health center to the *Health*

Links collaboration, a comprehensive system of care was finally in place to serve the uninsured and underinsured population of Franklin County.

Participation by the Franklin County medical community is high. Patients are now able to receive free or reduced-fee specialty care from over 90% of the local specialists, primary care from the health center, and all private internal medicine, pediatric and family practices, and free diagnostic services from the hospital.

To date, *Health Links* has provided accessible, affordable medical care to over two thousand individuals of all ages (several hundred children among them), including over ten thousand individual patient contacts. 90% of *Health Links'* patients reported gross family incomes of less than $22,000, and 90% had no health insurance, although 54% of those between the ages of 20 and 64 were employed at the time they used the service. Forty percent reported having used the emergency department within the two years previous to their contact with *Health Links*; many of these visits were undoubtedly preventable had the patients had access to a routine source of primary care.

The Health Links Advisory Board, which continues to meet quarterly, is composed of representatives of agencies serving large constituencies of the medically underserved population. In addition to the hospital and health center, these include Franklin County Home Care Corporation (the Area Agency on Aging), Franklin Community Action Corporation (the local CAP agency), the local United Way, Health Links patients and volunteers, and others. This group continues to monitor and oversee the *Health Links* program, and to consider additional projects and approaches to the problems of medical care access gaps in Franklin County. Unmet challenges now under discussion within this group include access gaps with respect to dental care and pharmaceuticals.

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Cooley Dickinson Hospital

Language Interpreting Services

Goal: To improve the access and quality of hospital services to community residents for whom English is not the primary language.

Target population: Non-English speaking Hampshire County residents

Description: The Language Interpreting Service allows Cooley Dickinson Hospital to provide quality healthcare to our non-English speaking or literate patients for both emergencies and scheduled appointments at all hospital locations. We have access to 30 specially trained and certified language interpreters who are available 24 hours a day, 365 days a year through Casa Latina Inc., a local community agency. Casa Latina provides interpreters who are fluent in Spanish, Polish, Russian, Khmer (Cambodian) and Vietnamese. Cooley Dickinson Hospital patients, their family members, physicians and hospital employees may request services as necessary.

As the population of non-English speaking Hampshire County residents continues to grow, it has become evident that interpreter services are needed. Cooley Dickinson Hospital and Casa Latina, worked together to plan and implement the Language Interpreting Services program. The partnership has strengthened both organizations by providing outreach in patients' primary languages.

Last year, over 300 individuals and families benefited from the Language Interpreting Services. Because of this program, these 300 people understood, had input and felt comfortable making decisions about their medical care. In addition, Cooley Dickinson Hospital was able to help support a local community agency and their mission, goals and objectives. Funding for the program is provided by the Cooley Dickinson Hospital as a community benefit. The funding includes a monthly payment to Casa Latina to administer the program and payment on a fee-for-service basis for the use of interpreters.

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Deaconess-Glover Hospital/Care Group

Parent Time

Goal: To organize an active family-support organization that provides educational, social and recreational activities for the families of pre-school age children in Dedham

Target Population: All families with children of pre-school age who reside in Dedham

Description of Program: The concept of developing a Dedham-based family-support network came about as a result of discussions held with members of the Dedham Community Health Committee (DCHC), a Deaconess-Glover Hospital-sponsored community health action committee. The DCHC brings together individuals who represent agencies, organizations and residents of Dedham who have a common interest in the health and wellness of Dedham. A Deaconess-Glover Hospital Trustee and the Director of Community Relations co-chair the DCHC.

The DCHC assesses community health status through analysis of formal and informal health surveys, evaluates public health data and conducts focus groups and group discussions around public health and wellness issues. The DCHC then collaborates on the planning, development, implementation and evaluation of programs. As a result of discussions that took place during the fall of 1997 among DCHC members and members of the Dedham community, representatives from the Dedham clergy and an informal telephone survey among Dedham families, the absence of a support organization for families with pre-school children emerged as a key issue.

To facilitate the founding of a Dedham-based family support, Deaconess-Glover engaged Needham residents Tammy Lamenzo and Wendy Perlman, the founders of Needham's Parent Talk, a family support organization with more than 400 members. Based on the overwhelmingly positive response to a series of survey questions about the viability of a similar organization in Dedham, the consultants worked closely with a Dedham resident, who is the mother of several young children, to develop an organizational framework. Family Service of Norfolk County, a Dedham-based human services agency, collaborated on this project by donating office space as well as administrative and technical support to the development and operation of this new organization named *Parent Time*.

Recruitment efforts have included making presentations at a number of different venues including Dedham's Family Unity Day, sponsoring a Classic Kids Film Fest, holding orientation meetings at local day care centers and staging play-times for parent and children get togethers. More than 75 Dedham families have joined *Parent Time*, with membership continuing to grow on a monthly basis. *Parent Time* held a Family Picnic in August, and has organized a monthly inter-generational social program called "Circle of Friends" with the residents of CareMatrix, a Dedham-based assisted living facility. *Parent Time* has also established more than one dozen play-time and play-group opportunities for Dedham parents and their children, publishes a monthly educational and informational newsletter, organizes social activities for parents, and has scheduled a series of educational lectures throughout the coming year.

Plans for next year include producing a periodic newsletter, scheduling playgroups, carrying out educational lectures and holding special social events for parent groups. As the reputation of *Parent Time* spreads, membership will continue to grow at an accelerated pace. The membership goal for the coming year is to recruit 178 member families by the end of this fiscal year. Family Service of Norfolk County will continue to provide office space and administrative support while Deaconess-Glover Hospital will offer in-kind services, when needed, and promotional assistance, meeting space and funds allocation for special activities.

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Deaconess-Nashoba Hospital/Care Group

The Violence Prevention Project

Goal: To raise awareness and address the problem of violence in the community, and to initiate a creative approach to violence prevention by going to children directly, giving them a voice with which to talk to other children and adults, positively and creatively.

Target Population: We hope to gain the particular attention of victims of violence, those at risk for violence, and students at an age when they are most likely to approach the issue of violence with articulate, creative ideas for change.

Description: In 1993, the Board of Trustees' Community Relations Committee – a standing committee consisting of volunteers from the various communities served by Deaconess-Nashoba – established violence prevention as a health priority. To address this issue, the Community Relations Committee first had to identify violence as a local health problem – no easy task in the rural isolation that is part of small towns in central Massachusetts.

A cross-section of the community – students, teachers, nurses, clergy, law enforcement and government officials, hospital staff – gathered at a forum held at Deaconess-Nashoba in 1994. Among the expert panelists were a judge, a chief of police, emergency medicine physicians, and a social worker. The 150 people in attendance cast new light on violence in the community, as they told their stories and raised their concerns. As a result of this interaction, the Committee worked to meet specific, urgent needs immediately:

- *Are You Being Hurt?* resource posters, *Time Out* tip cards, and emergency "palm cards" for people at risk were distributed within and outside the Hospital
- resource lists were distributed
- physician speakers for community groups were provided

At the same time, the Hospital focused on educating our own professionals – EMTs, emergency department and medical staff – on recognizing victims of domestic violence and establishing protocols for assistance.

By 1995, the Community Relations Committee realized that addressing the issue of violence after the fact was inadequate and discouraging. Prevention became the logical next step. The Committee convened another community cross-section, this time of the schools. Administrators, health educators, guidance counselors, nurses and teachers from both public and private schools came together twice at Deaconess-Nashoba. Many were excited to be meeting and working with their counterparts for the first time. The workshops produced these goals:

- to involve students directly in a violence prevention project;
- to implement the project across all communities; and
- to maintain cooperative efforts while dealing with the problem of violence.

Drawing from the educators' advice, the Committee decided to ask fifth grade children, in a positive way, their own ideas about violence prevention. The original intent was to use this

information as the basis for developing school, community, or hospital programs that would meet the needs of students, parents, and educators alike. The Fifth Grade Project began in the spring of 1996, with the question, "How can kids create peace in their lives?" Schools in eight towns participated, and over the next several months, 450 students responded with poems, posters, and essays. When the Committee reviewed the entries, they realized the students had done more than lead the way toward the next step: this was the next step.

By consolidating the entries, first into a travelling photo mural exhibit and then into a four-color, interactive book, the Committee succeeded in both empowering the children and inciting the interest of the adults. The adage, "Listen to the children," has become a plausible, simple start to a no-limits dialogue. The book, *The Voices of Children: Messages of Hope & Optimism for a Kinder World*, is being distributed as a community benefit by Deaconess-Nashoba. The Hospital has borne the costs of producing the book, under the umbrella of the Community Benefits budget.

The book, *The Voices of Children*, has been distributed to the 450 students who participated, to their teachers and schools, and to town libraries. To date, the book has reportedly been used as part of a conflict resolution, summer enrichment program in Clinton, and as part of a curriculum being developed at a middle school in Pepperell. It has been the focal point of a sermon in Townsend, the subject of a song in Westford, and a window display in the Concord Bookshop. WAVE (Women Against Violence Everywhere, based in Ireland) carried the book from the Regional Office of Health and Human Services in Boston back to their country. The photo mural exhibit continues to travel, and was most recently on display at the office of Health and Human Services in the lobby of the JFK Federal Building in Boston, at the invitation of Judith Kurland, Regional Director.

The Project began within the geographic area of north central Massachusetts defined as Deaconess-Nashoba Hospital's service area. Specifically, the towns of Ayer, Bolton, Dunstable, Groton, Harvard, Littleton, Lunenburg, Pepperell, Shirley, Townsend, and Westford. Since then, our neighborhood has stretched far and wide: the book, *The Voices of Children: Messages of Hope & Optimism for a Kinder World*, has now reached children struggling with violence in countries as far away as Ireland and Russia. To date, approximately 15,000 people have been involved in one or more activities of the Project.

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Deaconess-Waltham Hospital/Care Group

Proyecto Conexion de Latinos

Goal: Enhance access to quality primary care services for Latinos in Waltham, specifically for perinatal and parenting women, infants, children and adolescents.

Target Population: Latino Population in Waltham

Description: *Proyecto Conexion de Latinos* was developed in a collaborative consortium of 25 agencies in Waltham, led by Deaconess-Waltham Hospital over a period of 10 months in preparation for submittal to the Massachusetts Department of Public Health. During this period, the collaborative committee completed a needs assessment in English and Spanish, conducted focus groups, and interviewed key community leaders to identify unmet health and social needs in the Latino community. Funding was received in the fall of 1997 and the program has been up and running since then.

There are three strategies to the program:

- Add three essential services: Community Outreach, Interpreter Pool and a Teen and Tot Clinic
- Increase access to agencies which currently offer services needed by this priority population but which are inaccessible due to lack of culturally competent Spanish speaking staff as well as other barriers to care such as lack of financial resources including insurance
- Optimize resources through integration, coordination, and collaboration

The program currently employs a full time bilingual, bicultural outreach assistant. The staff currently works out of Waltham's community policing substation, where they share space with the community policing program, the DARE program, and Project Outreach -- an adolescent outreach program. This unique partnership allows for collaboration, integration, and support at all times.

Another exciting component of this program is the Proyecto Conexion Advisory Council. The council is a group of interested collaborators who meet on a monthly basis to assist and guide the project staff with ideas, projects, etc. Currently, council members are from the community, as well as from the Waltham Police Department, The Center for Mental Health, Support committee for Battered Women, Wayside Youth & Family Services, Maternal & Child Health, St. Mary's Church and Middlesex Human Services Agency.

The outreach staff along with the council, held their first *annual Proyecto Conexion de Latinos* health fair entitled: "Un Salto a la Salud," a city-wide health fair at a local playground in Waltham. Over 300 people, 90% being Latino, attended and were treated to over 15 interactive displays of health information and health screenings. As a result of the health fair held in late August, the number of referrals have increased, and data is being collected on the results.

The staff and council continue to seek to engage community members in a variety of manners to increase access to the programs and services available in the community of Waltham. We want to build strong networks for people, empower people, and break down barriers that impede access to health care and other services.

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Emerson Hospital

Cancer Awareness Day

Goal: Cancer Awareness Day is a community event designed to promote early detection and to increase awareness about cancer in general.

Target population: Adults (primarily over age 50)

Description: Each May, Emerson Hospital hosts *Cancer Awareness Day* – an exciting community event which includes free screenings, health lectures and general information about cancer. For the convenience of attendees, the event is always held on a Saturday, and is staffed by approximately 30 employees and 13 physicians representing disciplines from throughout the hospital. In addition, the American Cancer Society (ACS) provides an information booth and two volunteers who staff a Dermascan.

Emerson has held *Cancer Awareness Day* since 1994, and each year it has grown in size and scope. In 1998, more than 350 visitors attended the event. Emerson provided six free health screenings including:

- a full body skin cancer screening
- an occult blood test for colon-rectal cancer
- a respiratory screening
- prostate specific antigen blood test (PSA)
- a lipid profile cholesterol test.

Approximately 175 men and women were screened for skin cancer (25 biopsies were recommend); 53 individuals participated in the colon-rectal screening (no positives); and 200 blood tests were performed including 95 PSAs (15 high levels).

In 1998, Emerson introduced "Meet the Doctor Sessions." These one-on-one "mini consultations" were created to foster communication between attendees and Emerson's physicians. In previous years, guests routinely waited for an opportunity to speak privately with the physicians after their lecturers. The "Meet the Doctor Sessions" provided participants with an opportunity to speak to numerous specialists including, medical oncologists, surgeons, gastroenterologists, urologist, radiologists, and radiation oncologists.

Another important part of *Cancer Awareness Day* is the series of informational lectures offered by Emerson clinicians. This year, three lectures were held and the topics included *Understanding Cancer, Screening for Cancer* and *The Role of Nutrition in Treating & Preventing Cancer.*" In addition, there were 15 information tables staffed by representatives from many different departments including Social Services, Hospice, Home Care and the Pediatric Intervention Team.

To promote *Cancer Awareness Day*, Emerson features it prominently in the hospital newsletter and calendar as well as through press releases, paid advertisements and public service announcements.

Cancer Awareness Day was developed in response to our community's need for improved access to screenings and information. The event has been as tremendous success and Emerson will continue to offer and improve upon it.

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Franklin Medical Center
(a member of Baystate Health System, Inc.)
Combating Domestic Violence

Goal: Assisting victims of domestic violence.

Health Problem: Domestic violence in Franklin County.

Description: The Combating Domestic Violence collaboration between the Greenfield Police Department and Franklin Medical Center's Visiting Nurse Social Work and Outpatient Mental Health Services is unique and nationally recognized as an effective model for assisting victims of domestic violence. This program has placed "emergency response systems" in particularly dangerous homes and provided many educational programs in the community. Additional funding was obtained and the program was expanded to the Greenfield School System. This new collaboration provided opportunities for both direct services to students and families as well as the education of school staff.

Many clients who present for treatment at Franklin Medical Center have issues of domestic violence that impact their health status. Establishing programs to address these issues and assisting those involved to seek resolution of their situation have had lasting results in improved personal health status and decreased use of health care services.

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Good Samaritan Medical Center

Project Safe Refuge Domestic Violence Program

Goal: To provide a safe sanctuary for victims of domestic violence who are seeking respite from a violent situation.

Target Population: Victims of Domestic Violence in the Metro South, Greater Brockton community

Description: Good Samaritan Medical Center has identified and targeted Domestic Violence as a health care need. *Project Safe Refuge* is a multidisciplinary program to promote and ensure the health and safety of domestic violence victims. Emergency assistance to victims includes identification, evaluation, medical treatment, crisis intervention, and follow-up. The program is overseen by the *Domestic Violence Task Force*, which is comprised of nurses, social workers, security personnel, and other appropriate medical center employees.

Unique to Project Safe Refuge is a specially trained staff member, an advocate for the victim, who is on 24-hour call to provide assistance and support in developing and implementing a safety plan for the victim. Not only are medical center resources utilized in this safety plan, but also the advocate is in communication with a network of local agencies to expedite legal action and safe housing for the victim and, if necessary, the children.

Project Safe Refuge serves all 21 towns in the medical center's service area as well as the city of Brockton, but it has provided services to community police departments as far as 50 miles away. It serves about 200 victims a year.

The project is the first stage in the development of a victim's safety plan. It has successfully assisted victims in finding temporary safe housing, initiating contact with law enforcement officials, and instituting the process of obtaining a restraining order in the courts.

The Medical Center has designated a domestic violence advocate who is on call 24 hours per day to assist victims of domestic violence. She is a former police officer, herself a victim of violence in the home. She has received an *Excellence in Human Services* award from Community Service of Greater Brockton. Her role is to assist victims in the early stages following a violent encounter, work to provide counseling, referral and appropriate resource information. Additionally, she works within the Good Samaritan and greater Brockton community to develop policies and educate staff.

The medical center has a comprehensive series of policies and procedures for caring for the victims of domestic violence. These policies direct the actions of the emergency department, the advocate, other nursing professionals and social services. Medical care is provided as needed, and counseling is provided regarding escape from the abusive environment. The advocate becomes involved and assists in seeking shelter, law enforcement and other immediate crisis assistance.

This program provides absolute confidentiality for patients who wish to be sheltered. The patient's name is not included on the medical center computer, only key staff is aware of the circumstances and identity of the victim. Assistance is provided to those choosing this service to provide safety and security during the difficult and dangerous period during which an individual may be making life choices.

In addition to *Project Safe Refuge* and the *Domestic Violence Task Force*, Good Samaritan also sponsors the *Domestic Violence Community Round Table* to share information about the fight against domestic violence. Meetings of the roundtable include law enforcement, judiciary, education, social services, and community volunteers.

Other related efforts have included the *Walk for Women's Safety*. Good Samaritan Medical Center provided organizational support and financial assistance for the *Walk For Women's Safety* on Saturday, June 8, 1997, which raised funds for the Brockton Area Domestic Violence Action Program.

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Greater Lawrence Family Health Center

Lawrence Family Practice Residency Program

Goal: To provide primary health care to the underserved through an innovative, expanding, residency program.

Target Population: Low-income, predominantly ethnic families in Greater Lawrence.

Description: The Greater Lawrence Family Health Center was established in 1980 through a cooperative effort involving Lawrence General Hospital, Holy Family Hospital, and the Lawrence Community Action Council. At that time the area hospitals were beginning to see an increasing number of non-English speaking patients in their emergency rooms with what were considered primary health care needs.

The Health Center began seeing patients in late 1980 in two exam rooms on the second story of a local funeral home. In 1984, the Health Center purchased a building on Park Street and renovated it into a clinic with 16 exam rooms in the middle of one of the poorest sections of the city. In late 1988, a second site was added in South Lawrence to meet the increasing needs of an ever more diverse population. While the Park Street site serves a primarily Hispanic population, the South site is an eclectic mix of Anglo, Hispanic, Vietnamese, Cambodian and Lebanese patients. From 1980 to 1992, the Health Center grew slowly to care for approximately 9,000 patients at these two sites. The Health Center encountered tremendous physician recruitment and retention challenges; regularly caring for an underprivileged urban population can be emotionally draining for physicians and staff.

In 1992, The Health Center concluded that the only way it would ever approach meeting perpetually increasing needs was to establish a program to train family physicians to meet the medical needs of a low-income, non-English speaking, urban population. However, reimbursement for medical education comes from government and private payers exclusively through care provided at hospitals. For a residency program to be successful, it requires the determination and commitment of a strong hospital partner. The Greater Lawrence Family Health Center found that commitment in Lawrence General Hospital.

Lawrence General Hospital has always been committed to the urban population, though its service area extends well beyond the 7 square miles of the City of Lawrence. The hospital funded the research necessary for the Health Center to learn how to establish a residency program and provided more than $500,000 of start-up funding for program development. They were instrumental in the successful recruitment of residency leadership and served as the funding vehicle of the Health Center's Residency Program until 1994.

The creation of the Residency Program allowed the Health Center to offer more interesting and diverse positions to physicians that involved a combination of patient care, curriculum development, teaching and supervision. Since the development of the Residency Program, the Health Center has added 12 new physicians and, with the 24 family practice residents, has more than tripled the number of patients receiving primary care services in Lawrence. As a result of these advancements, low birth weights have been reduced and vaccination rates

have improved. The Health Center's growth has also provided over 200 additional jobs for Lawrence residents and is currently one of the city's largest employers, with over 300 employees.

For More Information, Contact:

Raymond D. Fredette
Chief Executive Officer
Greater Lawrence Family Health Center, Inc.
34 Haverhill Street
Lawrence, MA 01841-2884
978-725-7400

Hallmark Health

Cardiac Survival Project

Goal: To improve the response to out-of-hospital cardiac arrest by training the public in Cardio-Pulmonary Resuscitation (CPR), providing defibrillators to First Responders and increasing community awareness of the importance of the "Chain of Survival".

Health Problem Addressed: The low out-of-hospital survival rates for cardiac arrest on the North Shore.

Description: In the fall of 1995, under the leadership of Melrose-Wakefield Hospital, a community coalition was formed with the goal of understanding and improving the dismally low out-of-hospital cardiac arrest survival rates in our service area. Fire and Police Departments, the American Heart Association, the American Red Cross, ambulance companies, hospital Emergency Department providers and the Regional EMS office formed this core group representing the communities of Revere, Melrose, Everett, Chelsea, Wakefield and Saugus. Our first assignment was to assess the strength of the links in the "Chain of Survival" – early access to 911, early cardiopulmonary resuscitation (CPR), early defibrillation and Advanced Cardiac Life Support. We surveyed local EMS providers and studied Health Status Indicators from the Department of Public Health and looked at data from places such as Seattle, WA, where the survival rate rose to 35% after instituting a similar initiative.

The two weakest links in the chain were found to be early defibrillation and early CPR. In addition, community awareness of this issue was found to be virtually non-existent. It was imperative to strengthen these "weak links". To accomplish this, we made low-cost CPR training available to community members, provided Semi-Automatic Defibrillators (SAEDs) to local Fire Departments, and advocated for the Enhanced 911 (E-911) system to be implemented in all of our cities and towns. At the same time, we sought to raise awareness of the importance of learning CPR and having early 911 and defibrillation available in every community. We have been enormously successful in our plan and our project continues to expand. Recently, we have begun to offer First Aid training to the community and have made first steps in addressing the 'fifth link' in the "Chain of Survival" – prevention.

Since the inception of our project, we have provided CPR training to 8781 community members for as little as $5 (or for free if cost was a barrier for an individual) and we have provided 13 defibrillators to the towns of Winthrop, Revere, Everett, Saugus, Malden and Wakefield. Enhanced 911 has been implemented statewide and we have trained 23 Emergency Medical Dispatchers and 911 operators.

Most importantly, we have seen our training actually save lives. A defibrillator that we donated to the Saugus Fire Department saved the life of the father of one of our CPR instructors. In Wakefield, a teenager who had been trained just days before in CPR and the Heimlich maneuver by the Project saved his little sister's' life when she choked on a Fire Ball. As we look to the future, our success will be measured in sustainable increases in the out-of-hospital cardiac arrest survival rates. The *Cardiac Survival Project* will continue to

expand and look for innovative ways to improve the survival rates for cardiac arrest and raise awareness of this crucial public health issue.

For More Information, Contact:

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Hallmark Health
Melrose-Wakefield Hospital
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Harvard Pilgrim Health Care Foundation

Fit For Your Life Program

Goal: The *Fit for Your Life Program*, a partnership between Harvard Pilgrim and the Hebrew Rehabilitation Center for the Aged, aims to reduce the risk of falls in the at-risk elderly by implementing a program of weight resistance exercises that can become incorporated into an individual's daily life activities.

Target Population: the elderly.

Description: The *Fit For Your Life Program* is designed to promote fitness, mobility and independence in the elderly to the fullest extent possible. A 12-week, two-day-per-week, exercise training program, *Fit For Your Life* targets at-risk elders.

The at-risk elders are referred to the program from their Primary Care Physicians, with referrals coming from the many HPHC networks in the communities of West Roxbury, Roslindale, Hyde Park, and Jamaica Plain, as well as from the Hebrew Rehabilitation Center's community outreach efforts.

The decline in muscle strength and muscle mass during aging has been linked to physical frailty, falls, functional decline and impaired mobility. Falls among the elderly represent a major public health problem with substantial medical and economic consequences. The elderly have the highest mortality rate and experience the greatest degree of disability and dysfunction from falls. The cost of fall-related injuries among the elderly has been estimated at more than $7 billion per year. Falls are the leading cause of accidental death in persons over age 65. In the United States, 76% of deaths caused by falls occur in the 12% of the population over age 65. The rate of falls rises exponentially with increasing age for both sexes and all races.

While the *Fit For Your Life Program* was originally designed to improve the fitness of nursing home residents, the program has been modified to meet the needs of community-dwelling residents to improve their fitness and reduce the risk of fall. The program of progressive weight resistance, endurance and balance training is designed to improve muscle mass strength and balance, thereby reducing the risk of falls. The program focuses on teaching exercises that the participant can continue at home, thereby developing exercise habits that can be incorporated into a daily routine.

The program is administered by the Hebrew Rehabilitation Center for the Aged. The West Roxbury Health Center donates the use of its space and the services of a social service worker to help with transportation to biweekly meetings. Additionally, HPHC and the Hebrew Rehabilitation Center collaborate on the analysis of results and the screening of program participants.

The *Fit For Your Life* program is one of many grant-funded programs designed to initiate or strengthen healthy partnerships between Harvard Pilgrim Health Care associates and non-profit organizations in the communities it serves. Grants of up to $25,000 are awarded to

Harvard Pilgrim Health Care staff, affiliated clinicians, and network health centers to partner with a local community service organization on programs in four target areas:

- the prevention of HIV/AIDS
- unplanned teen pregnancy,
- substance abuse and violence
- programs that promote health among the elderly

Preference is given to programs that are:

- innovative and responsive in addressing the needs of the target area
- assert outcome measures which can be evaluated
- strive to reach the needs of specific diverse ethnic, racial, or cultural groups
- represent the geographic diversity of Harvard Pilgrim Health Care
- propose to complete a specific measurable goal in one year
- are sustainable beyond the initial grant

For More Information, Contact:

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Harvard Pilgrim Health Care Foundation
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617-859-5034

HealthAlliance Hospitals

Women & Infant Program (WIN)

Goal: Strives to improve birth outcome and promote optimal health and safety among high risk pregnant and postpartum women and infants up to one year of age.

Target population: Pregnant and postpartum women

Description: The *Women & Infant Program (WIN)* is a program of the HealthAlliance Diversified Visiting Nursing Association. The program assists women who may not otherwise receive adequate health care due to income, language barriers, lack of transportation or other factors. Women can receive help with health insurance, medical care, nutrition and information about pregnancy and child raising. *WIN* also acts as a central referral agency for assistance with housing, job training, education and substance abuse prevention. *WIN* provides education and group support for new mothers and fathers.

The *WIN* program developed out of the work of a group of obstetricians and community agencies who worked with young mothers and felt there existed a need for additional services for this population. A community advisory council composed of over 20 local agencies, medical providers and consumers meets quarterly to discuss program policies and progress.

WIN has served over 3000 people in the community through community outreach and specialized educational groups. The program has serviced a total of 500 families through home visiting services.

WIN clients who delivered before enrollment in the program had significantly fewer prenatal visits than those who enrolled during pregnancy. *WIN* clients who delivered before enrollment were also more likely to experience preventable complications during pregnancy than clients who enrolled during pregnancy. And, most importantly, *WIN* clients who delivered before enrollment had a higher percentage of low birth weight infants (<5.5 pounds) than those who enrolled during pregnancy.

HealthAlliance contributes approximately $100,000 a year for operational expenses.

For More Information, Contact:

For the WIN Program:
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HealthAlliance DVNA
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Other HealthAlliance Community Benefit Programs:
Augie Grace
Vice President of Community Relations
Community Relations Office
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Fitchburg, MA 01420
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Healthsource Massachusetts

Health Assurance, Road to Recovery, and Booster Buddies

Goal: To care about the health and well being of people living in the communities we serve, and to improve the lives of underserved people by funding programs that directly address unmet needs.

Target Population: This year, Healthsource provided funding to numerous groups and organizations through direct contributions and grants.

Description:

- Worcester Healthcare Outreach *Health Assurance* Program. *Health Assurance* links uninsured children to health insurance. Research indicates that children who are uninsured suffer more frequent illnesses than insured populations and are less likely to secure medical care and medications. Targeting uninsured children in Worcester Public Schools, this program aims to assure that all children in Worcester Public Schools have health insurance. A pilot program demonstrated 100% success in linking uninsured children to MassHealth or the Children's Security Plan.

- The American Cancer Society/Hope Lodge *Road to Recovery* program. *Road to Recovery* provides cancer patients with transportation and lifesaving access to world class cancer treatment centers throughout Massachusetts. Without this service, cancer patients would be forced to drive themselves or rely on their families. *Road to Recovery* reached 240 cancer patients, providing more than 2,000 rides to vital cancer treatment centers.

- Friends of Worcester RSVP *Booster Buddies* program. *Booster Buddies* gives one-on-one education about the importance of childhood immunizations. The goal of the program, which targets at-risk mothers after delivery in the hospital, is to increase the immunization rate of young children from 70 percent to 90 percent by the year 2000. Through *Booster Buddies* 1,356 new mothers received education and counseling about the importance of life-saving immunization for their children.

For More Information, Contact:

Jean Kapetanios, M.Ed., CHES
Manager of Health Promotion & Community Benefits
Healthsource Massachusetts, Inc.
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Worcester, MA 01608
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Heywood Hospital *and the* Greater Gardner Community Coalition

Gardner-area Health Access Program (GHAP)

Goal: To connect people with existing health care plans such as MassHealth, or to provide reduced cost medical services for those who do not qualify for existing plans.

Target Population: Uninsured people who live or work in Gardner, Templeton, Westminster, Ashburnham, Winchendon or Hubbardston.

Description: The *Gardner-area Health Access Program (GHAP)* is designed to:

- through outreach and marketing, identify and reach area residents who do not have insurance and who may qualify for MassHealth or other health insurance
- assist identified people in completing applications for existing insurance
- for those who do not qualify for Masshealth or other programs, but who meet income guidelines of 133-400% of poverty, to enroll them in *GHAP* as an alternative to health insurance
- provide medical care and services through a network of 60 doctors who have agreed to provide care at greatly reduced cost. Members are issued cards, choose a primary care doctor, and pay for their own care according to a pre-established fee schedule. A typical office visit will cost a *GHAP* member $5 to $24 depending on their income level. *GHAP* members receive hospital care and services through the Free Care/Partial Free Care program or receive hospital-provided free care

GHAP serves a population of 50,000 residing or working Gardner, Westminster, Templeton, Hubbardston, Winchendon and Ashburnham. The program was formed by the Greater Gardener Community Coalition in response to health needs assessments conducted in 1996 and 1998. These studies emphasized the point that lacking health insurance is a significant impediment to accessing care for the 14% of the population who are uninsured, despite the fact that area physicians report that they provide a great deal of free care. People are reluctant to seek care for which they have no means to pay and instead often end up in the Hospital's emergency room in crisis.

The two health needs assessments were completed by members of the Greater Gardner Community Coalition and the Fitchburg Safe and Healthy Neighborhood Coalition. Both coalitions have broad community membership. Community partners such as the Gardner Visiting Nursing Association (GVNA), the Gardner clergy, Gardner Police Department, the Winchendon CAC, the Templeton Council on Aging, Mount Wachusett Community College and the Montachusett Opportunity Council (among others), participated in the health assessment and determined the priority issues for follow-up action.

Nearly every doctor on the staff of Heywood Hospital has agreed to participate in *GHAP*. Other community agencies such as the GVNA, Community Health and Prevention/Spectrum, and area mental health providers agreed to provide services at greatly

reduced fees for *GHAP* patients as well. We are working to enroll providers of such services as optometry and prescription drugs.

As of September 30, 1998, nearly 793 people have been screened through the *GHAP* program. Of those, 157 are now members of *GHAP*, 254 have been enrolled in MassHealth, 56 in CMSP, 7 in Healthy Start, 18 in small business plans, 79 in other plans, and 151 did not qualify or did not follow through.

One of our first *GHAP* patients is a lasting example of the success of the program. Our patient needed a total hip replacement, which would involve a physician fee payment of around $400 instead of the Medicare rate of $2000. The anesthesiologist received $166 instead of $832. The patient also needed rehab services not covered under Free Care, as well as home care services. The hospital agreed to provide true "free care," which is not reimbursed for the rehab stay, and the GVNA saw the patient for $14 per day.

The complexity of the care required, and the expense that everyone incurred was a significant test of *GHAP*. Everyone did what he or she could to help and the patient followed through with those payments he was required to make. The end result was a happy *GHAP* member and a person who received some badly needed care that has vastly improved the quality of his life.

The story of our hip replacement patient is but one example of how *GHAP* impacts on people's lives. The program has received numerous cards and letters from people who are grateful for the help in getting on MassHealth, or who now have *GHAP* and therefore are no longer afraid to go to the doctor when they don't feel well.

For More Information, Contact:

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GHAP
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242 Green Street
Gardner, MA 01440
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Facilitator of the Greater Gardner Community Coalition
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Holy Family Hospital and Medical Center

Colon/Rectum Cancer Joint Community Task Force

Goal: To establish the risk factors for colon/rectum cancer, identify effective screening mechanisms, present available treatment options, and increase public awareness without undue alarm.

Target Population: Adults in Methuen and nearby communities affected by a statistically significant ($P<0.001$) incidence of colon/rectum cancer.

Description: In December of 1997, the Massachusetts Department of Public Health, Board of Environmental Health Assessment, notified the Methuen Board of Health of a statistically significant ($P<0.001$) incidence of colon/rectum cancer in Methuen males. This observation was taken from Massachusetts Cancer Registry data issued by the Massachusetts Department of Public Health. Methuen's Public Health Director wrote to the hospital president, asking for assistance in communicating this issue to the residents.

In January of 1998, the hospital president extended an invitation to various hospital staff and community agency representatives to become members of a task force. The primary focus would be to seek out and implement ways, in conjunction with the Methuen Board of Health, to raise public awareness on the issue of colon/rectum cancer. All invitations to serve on this committee were accepted and the first meeting was held on January 29, 1998. Members on the task force represented:

- Holy Family Hospital (Administration, Nursing, Clinical Nurse Educators, Cancer Management Center, Public Relations and Community Benefits)
- Holy Family Hospital Medical Staff (Cancer Management Center, a surgeon, Co-chair, Cancer Committee, and an Internist/Gastroenterologist)
- Methuen Board of Health
- Massachusetts Department of Public Health
- American Cancer Society

Sub-committees on Screenings, Public Education and Speaker's Bureau, and Public Awareness were created; each community partner took an assignment on one of the sub-committees. A formal educational program was developed. Staff and physicians made themselves available to provide community outreach and education as needed.

Approximately 50 persons have attended the two public programs held to date. One program was presented at the Methuen Senior Center, and a second program was conducted in this hospital's auditorium.

Newspaper articles have appeared monthly in local newspapers, identifying colon/rectum cancer as being the second most frequently diagnosed malignancy in the United States, and informing the public of the elevated rate of this particular cancer in the Merrimack Valley. The articles also contain information on risk factors, prevention and ways to schedule available speakers to make presentations to the public.

The anticipated impact on the community is that heightened public awareness of colon/rectum cancer will encourage routine medical care, including screenings for colon/rectum cancer, and that an understanding of the risk factors will promote behavioral change where appropriate.

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Hubbard Regional Hospital

Hubbard Regional Hospital's Wellness Program

Goal: To increase the availability of preventative and early detection services to the at-risk populations including the poor and medically under-served. through free or wholesale Community based preventative, screening and early detection services.

Target Population: Women & seniors.

Description: To achieve our goal, Hubbard Regional Hospital administers influenza vaccines free to community members. Last year, over one thousand shots were given. We continue to offer free prostate screenings and PSA tests, with more than three dozen tests administered to local men during Men's Health Week.

The hospital also offers free mammograms for the uninsured and under insured during Breast Cancer Awareness Month. A portion of the funding from this program is derived from a Breast Cancer Walk, sponsored by Ultimate Touch, a local beauty salon in which all of the proceeds are donated to the hospital.

In addition, Hubbard will also:

- Participate in/spearhead elder health fairs.
- Provide free monthly blood pressure screenings.
- Increase involvement in senior centers through board membership.
- Offer free cholesterol screenings
- Continue to offer discounted meals on a daily basis to the local elder community, thereby ensuring elders are receiving nutritional and cost-effective meals while having an opportunity to socialize with their peers.
- Provide nutritious meals to the local Head Start programs.
- Offer psychiatric and counseling services in both inpatient and outpatient settings for issues particular to the aging.
- Through our Human Services Center, we will also assist and counsel nursing home staff and the family members of aging loved ones.
- Continue annual fundraising event through Hubbard Health Systems Primary Care Group in which all of the proceeds are donated to the Webster Dudley and Oxford Senior Centers.
- Offer community CPR, First Aid and Baby-sitting training.
- Continue offering free transportation for those surgical patients who require transportation to and from pre-operation physicals and to and from surgery.
- Continue working through DPH with an Institutional Case Finding Grant for smoking cessation programs and counseling.
- Continue to look for ways in which to expand in order to include additional programs and services targeted for the elderly. For instance:
    - Transitional Care

- Nursing Home. Working with Sunrise Health to open a state of the art extended care
  facility on hospital grounds
- Assisted living. We have broken ground to build an 80-unit assisted living complex with Christopher Heights, Inc. Half of the units will be offered to low and moderate income elders.

- Working with YMCA to develop a "Y" on property donated by Hubbard Regional Hospital.

Needs are identified by using the following mechanisms:

- Community Needs Assessment Report
- Patient satisfaction surveys
- DPH studies
- Managed care studies
- Collaboration with community members, social agencies and other health care organizations to improve the availability of health care services.

For More Information, Contact:

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Public Relations
Hubbard Regional Hospital
340 Thompson Road
Webster, MA 01570
508-943-2600

Jordan Health Systems

Mother to Mother: The Breastfeeding Peer Support Program

Goal: To increase to at least 75 percent (from the current 53.3 percent in the Greater Plymouth Area) the proportion of mothers who breastfeed their babies in the early post-partum period, and to at least 50 percent (from the current 25 percent) the proportion who breastfeed until their babies are 5 to 6 months old.

Target Population: All mothers interested in breastfeeding their infants in our 14-town service area on the South Shore.

Description: *Mother to Mother: The Breastfeeding Peer Support Program* is a collaborative project of Jordan Health Systems, the Plymouth WIC Program and community residents. This program is one example of several initiatives affiliated with the Greater Plymouth Area Healthy Communities 2000 Project – the "umbrella" community benefits plan of Jordan Health Systems, Inc., Plymouth.

The *Mother to Mother* Program offers free weekly support groups and daily access to telephone consultation to mothers throughout the Greater Plymouth Area who are interested in breastfeeding their infants. Thirty trained volunteer peer leaders provide counseling through support groups, which meet weekly at the hospital, serving from 5 to 22 women in each session. Volunteer peer leaders are also available by phone seven days a week to offer information and support to nursing mothers throughout the Plymouth area (the service area covers a 14-town region throughout the South Shore and Upper Cape Cod). We utilize existing networks throughout the region to promote the program, e.g., Plymouth Family Planning and Plymouth WIC participants, the Middleboro Teen Parent Support Group, area childbirth and parenting education programs, the CHNA, physicians offices, Pilgrim's Hope Shelter, South Shore Community Action Council (Head Start Program and Day Care Centers), MSPCC/Good Start, etc.

Jordan Health System's Lactation Center and the Plymouth WIC Program began this initiative in October 1997. At that time it was the only partnership of its kind in Massachusetts between a hospital and a WIC Program. The aim was to train peer counselors to teach nursing mothers who are eligible to receive nutrition assistance and education from the Women, Infants and Children Program that breastfeeding is the preferred method of feeding infants. The partnership promoted the fact that breast milk is uniquely designed to meet the complete nutritional needs of their infants. Last year the American Academy of Pediatrics recommended mothers breastfeed their babies for at least 12 months from birth.

The program is one of the many community-based initiatives that focus on building healthier families in the Greater Plymouth Area and has grown to embrace all nursing women throughout the region. The need to help build healthier families was identified through focus group discussions of community leaders and others conducted during the 1996 Community Health Needs Assessment. Contributing to this need was the ever-growing number of women contacting Jordan's Lactation Center specialists with questions about breastfeeding; the hospital has a limited number of professionals who were available to

provide this service. Our slogan, "Healthy families help build healthy communities." was created to illustrate the foundation of our Healthy Communities 2000 Project. *Mother to Mother*, together with such programs as the new Active Parenting Program (another example of one of our community-based, collaborative programs through the HALT Community Project), the new *Make Way for. . . Dad!* support group for new fathers, and Jordan's existing parent and family education programs, affords all parents in the area access to education and support in nurturing and parenting their children. The program is one of several parent education/support community-based initiatives based on information provided in one of many "community health panels" conducted as a part of the 1996 Community Health Needs Assessment.

The model includes Jordan and the WIC office as catalysts for the program, providing identification and training of peer leaders to conduct breastfeeding support programs and phone consultation for area mothers. Thirty volunteers together with the health system and WIC office collaborate to promote and provide this service free of charge. Space and refreshments are provided by the hospital.

For More Information, Contact:

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JoAnne Bryant
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Plymouth, MA 02360
508-757-4933

Kaiser Permanente

Dues Subsidy Program

Goal: To improve the health of the community by making high quality health care affordable for a specific period of time.

Target Population: Financially challenged/uninsured in Berkshire, Franklin, Hampden and Hampshire counties

Description: As the nation's largest non-profit health maintenance organization, Kaiser Permanente is dedicated to providing quality, affordable health care. The *Dues Subsidy Program* is offered as a community service to help qualified individuals keep or obtain our high quality health care at a very special low rate for a limited duration. To qualify for the program, applicants must meet specific eligibility and income requirements. We offer two levels of subsidy, 85% and 50%, depending on household income. The program has a lifetime maximum of 36 months.

Currently, there are 306 participants in the *Dues Subsidy Program* in Massachusetts.

The need for this type of program is evidenced by the millions of uninsured people in the country. Kaiser Permanente's commitment to improve the health of our communities is a long-standing tradition and the *Dues Subsidy Program* is just one example of this tradition.

Additional Features: A list of bilingual providers and staff is updated regularly and circulated to all health centers for use in assisting members with selection of a provider and to identify potential interpreters as appropriate. Enrollment applications have been designed to include a language preference. This information is captured in the membership database to track members' language preferences. All members receive a welcome call at the time of enrollment. Any special language needs are noted and documented in the members' medical chart, and a bilingual provider, interpreter, or use of the Language Line is provided for health center visits. The free Healthwise Handbook is available in Spanish. Other translated health education materials cover topics such as diabetes, asthma, maternity length-of-stay regulations and health care proxy forms.

Eligibility: An applicant must have lived in Kaiser Permanente's Massachusetts Service Area for the twelve consecutive months prior to applying. Applicant's income and assets will be reviewed and evaluated. For 1998, applicant's annual Household income must be less than:

	To qualify for 80% subsidy	To qualify for 50% subsidy
1 person household	$12,075	$20,125
2 person household	$16,275	$27,125
3 person household	$20,475	$34,125
4 person household	$24,675	$41,125
5 person household	$28,875*	$48,125**

* Each additional person, add $4200

** Each additional person, add $7000

Other requirements and restrictions:

- Every adult individual in applicant's Household must be employed full-time, actively seeking full-time employment, primarily responsible for caring for dependents who require full-time care, or unable to work due to disability
- Applicant may not be eligible for any health insurance program for which all or part of the fees are paid on applicant's behalf. This includes Medicare, Medicaid, employer programs and student health insurance
- Applicant may not be self-employed

Participation in the *Dues Subsidy Program* is limited to:

- A maximum of 36 months per lifetime
- Up to three separate enrollments (if applicant loses eligibility, reapplies and is accepted again) until the 36-month maximum is reached

Participation in the *Dues Subsidy Program* is subject to:

- Space available in the program
- Periodic review of members' finances
- Continued residence in the Massachusetts Health Plan Service Area

COSTS TO THE ELIGIBLE:

If accepted for the *Dues Subsidy Program*, applicant will receive either an 85% or a 50% subsidy depending on applicant's income. For December 1, 1998 to November 30, 1999, the monthly payment would be:

	50% subsidy level		85% subsidy level	
Subscriber Age	Single	Family	Single	Family
<30	$111.72	$242.59	$33.51	$72.78
30-39	111.72	291.33	33.51	87.40
40-49	121.99	314.80	36.60	94.44
50-59	200.19	338.49	60.06	101.55
60-64	223.43	485.17	67.03	145.55

Income guidelines are based on the 1998 Federal poverty guidelines.

For More Information, Contact:

Mary Ellen Kunz
Manager, Community Relations
Kaiser Permanente
200 Corporate Place
Rocky Hill, CT 06067

Interested applicants should call 1-800-550-9389, option #5.

Lahey Clinic

Domestic Violence Initiative, A Lahey Clinic/Community Partnership

Goal: To heighten the public's awareness of domestic violence issues, train Lahey Clinic staff, work with community agencies to recognize and respond to the needs of the victims of domestic abuse, and provide crisis intervention for victims in need of protection from batterers.

Target Population: Victims of Domestic Abuse in any community served by Lahey Clinic (particularly those from CHNA #15)

Description: Currently led by Susana Rey-Alvarez, MD (recipient of the *Voice for Justice* award 1998 by the Support Committee for Battered Women), The *Domestic Violence Initiative* was formed in 1992 in response to a community needs assessment and prior experience by the Lahey Clinic Cluster Committee for Health Care Planning. The Cluster Committee was a collaborative group of Lahey Clinic staff and community partners representing organizations such as the Police Department, Support Committee for Battered Women, the District Attorney's office, local schools, home care agencies, local social service agencies, and clergy. The continued assessment of top unmet health and social needs in Burlington was accomplished through a 1996 Community Benefit needs survey. This was coupled with a study of DPH health status indicators in CHNA #15, which underscored domestic violence as one of the community benefit priority areas of unmet health needs within Lahey Clinic's Community Benefit Initiative Plan.

In response to the reality that domestic violence is often ignored or unrecognized, the *Domestic Violence Initiative* has and will continue to utilize education and advocacy to provide awareness education, risk assessment and crisis intervention training for all employees with particular emphasis on physician universal screening. Community education efforts have included the *Breaking the Silence of Teen Dating Violence* and the *Breaking the Silence of Elder Abuse* programs funded by the Harvard Pilgrim Health Care Foundation.

Efforts to fund an outreach victim advocate to coordinate the Safe Haven program in FY99 at the conclusion of the internal Lahey Clinic physician and *staff Universal Screening Program* training is underway. Grant opportunities to fund this collaborative effort between Lahey Clinic and the Support Committee for Battered Women are currently being sought.

Educational Program Effort (FY 97 & 98) numbers are as follows:

- 19 social workers and case managers and approximately 35 emergency department staff trained as in house experts on crisis intervention and safety planning for victims.
- 3,144 employees trained to recognize signs and symptoms of suspected abuse as well as accessing resources.
- 60 physicians trained in Universal Screening with plans to train the remainder of the total of 240 Lahey Clinic Physicians to include those in primary care community practices.
- Approximately 900 students (with specialized training for peer leaders)and over 50 teachers and other school personnel at Burlington High School participated in

multimedia and classroom education by experts on teen dating violence prevention and intervention education.

- Currently, over 100 elders have attended community education forums on Elder Safety issues including elder abuse. 5 elder victims are scheduled to participate in a Support Group, developed as part of the elder abuse program, coordinated by community partner, Protective
- Services of Minuteman Home Care.
- Approximately 1200 visits to the Domestic Violence Burlington Police Department web site, funded by the Robert E. Wise Foundation at Lahey Clinic were logged in the first year.

Once the Safe Haven is established with appropriate onsite staff resources, outcome measures such as tracking of proactive and reactive identification of victims throughout Lahey Clinic's Emergency Department, outpatient clinics (averaging 2500 outpatients daily, and inpatient units and corresponding intervention results will be recorded. The Domestic Violence Committee and task forces will continue to provide pre and post education evaluation of staff and community agency symptoms and intervention resources available. Skill level competency of intervening staff and status of victims post intervention will be evaluated through the case study method.

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Lawrence General Hospital

Sexual Assault Nurse Examiner Program (SANE)

Goal: To improve the quality of care for victims of sexual assault.

Target Population: The Program serves victims of sexual assault seeking care in the emergency department of the hospital.

Description: *The Sexual Assault Nurse Examiner Program (SANE)* certifies the hospital's emergency department nurses to provide extraordinary support and medical-legal exams for victims of sexual assault. The primary objectives of the program are to:

- provide immediate crisis intervention to support the patient
- offer prophylactic treatment when the patient desires it
- use a standardized protocol for forensic evidence collection
- refer to supportive community agencies
- increase the conviction rate of perpetrators

Nurses receive intensive training to properly collect forensic evidence that would be admissible in court should the victim decide to prosecute. *SANE* provides on-call services 24 hours a day. The 14 nurses who received the training for the model program volunteered to participate, and our experience has shown that the demands of the program require a high level of commitment.

A local committee -- composed of representatives of the hospital, local police departments, shelters, counselors, advocates and prosecutors focusing on domestic violence issues – first identified the need for this program. Their concerns meshed with those of the Commonwealth; in 1996, the Office of former Governor William Weld moved to set up statewide systems to address the problem. Because of its local efforts, Lawrence became the program's first self-contained site in the State, established and administered by the Massachusetts Department of Public Health. In addition to the Department of Public Health, and the Bureau of Family and Community Health, the hospital worked closely with Kevin Burke, Essex County District Attorney and the local Women's Resource Center to set up the *SANE* prototype.

Since the program was formally launched in February of 1997, the nurses have cared for 90 patients. As part of its community benefit program, the hospital contributes the cost of the nurses' time in training and other costs, which are not reimbursed. Most recently, the Department of Public Health purchased and donated a Med-Scope device to the program. Med-Scope enables the examiner to detect and capture video evidence of even micro-trauma by magnifying it 40 times. Outcomes from the use of the scope will be measured. If it proves effective, it will be made available throughout the rest of the State.

Ultimately, *SANE*'s success will be measured by tracking the success of post-trauma care and prophylaxis and by assessing its effectiveness in increasing the conviction rate for perpetrators of sexual assault.

In April, 1998, the *SANE* Program at Lawrence General Hospital was among the innovations of the year honored by the Massachusetts Department of Public Health during National Public Health Week.

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Lower/Outer Cape Community Coalition

Community Health Needs Assessment Project (CHNAP)

Goal: To compile information on those underserved or underrepresented by the health care industry as a foundation for future actions and policies.

Target Population: Residents of Barnstable County.

Description: The Cape Cod Community Health Needs Assessment Project is a study of accessibility to health services by underserved and underrepresented groups within Barnstable County. At a time of much structural and organizational change within the health care system of Cape Cod, the CHNAP has collected benchmark information upon which future health care policies and programs will be built.

Begun in the fall of 1997, the CHNAP probed four health-specific areas: dental, medical, mental health and preventive health services for certain groups of Cape Cod's year-round population. The population groups on Cape Cod that the CHNAP studied are those who are normally *not included* or *underrepresented* in research. For the purposes of the CHNAP, the definition of "under-served and under-represented people" included:

- People living in low-income households;
- Cultural and linguistic minorities;
- Uninsured and under-insured people;
- People who have only seasonal employment, who are self-employed, or who are unemployed;
- Gay, lesbian, bisexual, and transgender people;
- People without access to public or private transportation;
- Homeless people;
- People living in physical isolation; and
- Disabled people.

The CHNAP process also included organizing seven community forums throughout Barnstable County. The CHNAP survey and community forums were designed to answer the following questions:

- If you , your partner, or a family member feels sick or needs preventive health care, is there a place for you that: you can get to?
- you can afford?
- speaks your primary language?
- gives you quality care?
- understands your culture?
- treats you with respect?
- incorporates your feedback into services?
- provides linkages with other services?

The CHNAP was unique in the recent history of Cape Cod. It was a public study that was co-sponsored by Cape Cod Healthcare and the Barnstable County Department of Human Services with assistance from Cape Cod Child Development Programs, Falmouth Human Services, JRI Health, the Massachusetts Department of Public Health, the Massachusetts League of Community Health Centers, Health Care of Southeastern Massachusetts, Hospice of Cape Cod, Lower/Outer Cape Community Coalition, the O'Neill Center/NOAH Shelter, Outer Cape Health Services, the Provincetown AIDS Support Group, and the Visiting Nurse Association of Cape Cod. In addition to the steering committee members, many other community volunteers participated in the organizing efforts to involve the people of Cape Cod that we sought to reach through the survey research and community forums. Without this diversity of institutional and community support, the CHNAP would not have been possible.

The survey research and community forums were conducted during March and April of 1998. In September, the CHNAP Steering Committee will present the findings and conclusions to a joint meeting of the Cape Cod and Falmouth Hospital Community Benefits Advisory Councils and the Community Health Network Area 27. The Steering Committee will then return to the community to share the CHNAP results, receive feedback from the community, and mobilize individuals and organizations for strategic planning to meet the primary access needs of the underserved.

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Lynn Health Task Force

Lynn Health Task Force and AtlantiCare/North Shore Medical Center.

Goal: A community-driven effort to negotiate improvements in community health and hospital services in a hospital merger agreement.

Target Population: Residents of Greater Lynn.

Description: In the summer of 1996 the Lynn Health Task Force (LHTF), a community organization with a twelve-year history of activity for expanded health care access in the Greater Lynn area, began a project to identify unmet health care needs in the city. The Task Force aimed to cover these needs through the community benefits obligations of area hospitals, such as AtlantiCare Medical Center.

Many of Lynn's needs were already known: One-third of Lynn's approximately 80,000 residents and 26% of Lynn children live in homes with incomes under 200% of the federal poverty level ($32,100 for a family of four). The city has the lowest primary care physician to patient ratio in eastern Massachusetts. It has a large population of non-English speaking individuals, including significant Latino, Southeast Asian and Russian communities. According to the Massachusetts Department of Public Health (DPH), the city has high rates of teen pregnancy, substance abuse, infectious disease, and high rates of injury and death due to violence and low rates of prenatal care.

Based on the DPH statistics, a needs assessment done by the Lynn Community Health Center, and interviews with LHTF members (more than eighty individuals and agencies), The LHTF compiled a list of needed hospital services and community health improvements. A November of 1996 community speakout, attended by over sixty participants, reinforced the assessment's findings. The issues identified were:

- serious lack of primary care services in Lynn,
- the need for a walk-in service in central Lynn,
- the need for expanded free care services at AMC (including prescription drugs, laboratory services and specialty physician services),
- the need for more interpreters at AMC,
- the need for expanded and coordinated transportation,
- the need for information and outreach on free care and available public insurance programs,
- the need for increased community-based services for substance abuse, infectious disease, violence prevention, mental health and dental care.

AtlantiCare Medical Center (AMC) had filed its community benefits report in August, 1996. Finding it inadequate in light of the identified needs, the Lynn Task Force filed a critique with the Attorney General and requested meetings with AMC. At about the same time, AMC announced its intentions to sell the hospital. The Task Force sought a central role in this process to better ensure that AMC remained open and willing to address community health issues. AMC agreed to this involvement.

The Lynn Health Task Force submitted questions to all four competing bidders, and AtlantiCare hosted a public meeting for the community and the Task Force to hear out each bidder. The LHTF used this information to rank the bidders and determined that Partners HealthCare was the strongest of those interested. After meeting with the

Task Force, Partners/NSMC expressed its commitment to the community in writing, which LHTF passed on to the AtlantiCare Board of Trustees. On April 24, 1997, AtlantiCare's Board of Trustees voted to merge with North Shore Medical Center, and the Massachusetts Department of Public Health' Public Health Council approved the merger on October 28, 1997. AtlantiCare cited two key reasons for its decision: the hospital's preference to keep the care of its patients in local hands and the value of the NSMC/Partners community health commitments. This was the culmination of an extraordinary community action.

The conditions of the merger, besides the Determination of Needs provisions, addressed issues such as filling Board vacancies, holding public forums prior to electing Board nominees and other methods to increase community input into Board composition. As a result of this collaboration, the AMC Board of Trustees is more diverse and more reflective of the Lynn community:

Before the merger:	**After the merger:**
12 members (11 men and one woman)	22 members (15 men, 7 women)
No minorities	6 minorities

As for the Determination of Needs Provisions, significant advances have been made:

- Two outreach workers were hired to assist patients applying for publicly funded health insurance and to improve uninsured patients access to care. (One of these outreach workers, a Khmer woman, is a new member of the AMC board).
- Funding for a new clinic at Breed Middle School to promote and improve routine primary care as part of adolescent health
- Establishment of a primary care walk-in service on Boston Street in Lynn
- Funding, through the HAWC program for two domestic violence counselors, one to be stationed at AMC and one at NSMC
- Funding for two adult counselors at Girls, Inc. to provide teen pregnancy information and support
- Maintenance of a free van service with the addition of four stops at senior citizen apartments, and an assessment of the complex transportation problems for AMC patients
- Funding for expanded services at Cornerstone For Life, an HIV counseling and support center

Other efforts are still to be finalized: Expansion of primary care services. The hospitals and the Lynn Community Health Center jointly identified a total need of 15 new primary care physicians. Negotiations between the health center and the hospitals to finalize an affiliation agreement to provide capital support and operating revenue for initial expansion of primary care services is nearing completion. The Task Force seeks a definite commitment for further expansion.

The community benefits and merger negotiations have led to an increasingly collaborative process between the Lynn Health Task Force and AMC/NSMC/Partners. According to the hospitals, improving communication and interaction between the community and hospitals has become a NSMC priority.

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Mary Lane Hospital

(A member of Baystate Health System, Inc)

Health Education for Children

Goal: Improved health and well-being of children.

Target Population: Children from early childhood through adolescence.

Over the last several years, Mary Lane Hospital (MLH) has focused on youth health by offering educational opportunities for children from early childhood through adolescence. Examples of school-based involvement are as follows:

- Pre-school level: Mary Lane Hospital professionals were active in promoting youth health and safety. In the Community Health Information Center operated by MLH, children from our local Head Start group participated in a teddy bear clinic and toured MLH to prepare them for a positive first time experience in a hospital.

  An MLH based pediatrician identified the need for a toddler play group within the community. A Toddler Center was then created through the collaborative efforts of the MLH community outreach coordinator, interested agencies, and parents. This center provides parents and their children with an opportunity to share parenting advice and learn from each other.

- Elementary school level: An after-school safety program was conducted at the Hardwick Elementary School for fourth through sixth graders and their parents in response to concerns about the safety of children who have to stay home without adult supervision after school to care for themselves and/or younger siblings. This seminar, a collaborative effort between the elementary school, Paige Memorial Library in Hardwick and MLH, covered topics such as injury prevention, fire safety, basic first aid, rescue breathing, choking, proper hand washing, safe food rules and baby-sitting skills. MLH staff also conducted educational programs for other students, including a CPR, respiratory, and cardiac system education program for fifth graders.

  Mary Lane Hospital also received recognition from the Ware Elementary school as a "Partner in Education" for its work with Junior Achievement.

  Personal safety outside the home was a community concern that also received attention. Keying in on a local town fair's theme of "There's No Place Like Home", the Community Outreach Services Committee provided Kid Care Photo I.D.s, that included an identification booklet with personal information as well as a Polaroid photo, which could be used by parents and law enforcement officials in the event of the child being lost or abducted. Over 400 I.D.s were provided at this

one event. In addition, the MLH Safe Kids Summer Celebration provided educational information on child safety as well as a 10-station safety obstacle course for over 1,000 children.

- Secondary school level: Educational opportunities at the high school level have included educational forums for both youth and teachers on topics such as breast self exam, sexually transmitted diseases, teen pregnancy, eating disorders, date rape, and attention deficit disorder. A program using the *Baby, Think It Over* Doll instructed youths on the proper handling of a child, with the intention of deterring teen pregnancy.

  Working collaboratively with local educators, such as the Pathfinder Regional Vocational Technical High School Health Advisory Committee, administrators and school committee members for the Town of Ware, MLH staff have assisted with the development and implementation of new health curriculum and career training programs.

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The Massachusetts Eye and Ear Infirmary

The Vision and Hearing Care "Adopt a School" Program

Goal: To provide vision and hearing screenings and needed follow-up care to the students of the Neighborhood House Charter School in Dorchester, MA.

Target population: Students of the Neighborhood House Charter School in Dorchester, MA with pediatric vision and hearing problems.

Description: The Neighborhood House Charter School (NHCS) was founded in Dorchester, Massachusetts in 1995. Prior to the implementation of the *Vision and Hearing Care Pilot Program*, the Neighborhood House Charter School did not have the means to provide vision or hearing screenings for its students. The school initially opened with 51 students in grades K-2 and has now expanded to 145 students in grades K-7. Most of the students are from low-income families, most are minorities, and 90 percent live in Dorchester.

The Infirmary developed the *Vision and Hearing Care Pilot Program* after the Infirmary's Community Benefits Advisory Committee expressed an interest in working with Boston area children. The committee felt that providing vision and hearing care to students of a Boston inner-city school would be the most efficient and effective way to meet this goal. The Infirmary selected the charter school for the pilot project after the school expressed an interest in the program. The Infirmary's pilot program involves conducting vision and hearing screenings and then working with the students' parents/guardians to ensure that those in need receive follow-up care, regardless of their ability to pay.

One example of the success of the program is the five-year-old child whom Infirmary physicians identified as having serious visual problems – to the extent of being legally blind. The child was brought to the Infirmary for follow-up testing and his vision was corrected. A treatment plan was established for his eye muscle problems. Teachers at the school report that his schoolwork has improved immensely and that he is much more outgoing since his treatment.

Another example: during the second school year, the Infirmary provided an FM audio system for a young girl having difficulty hearing in the classroom. This device allows the student to hear her teacher's voice more clearly. Members of the Infirmary's Department of Audiology provided training on the system's operation and maintenance to teachers at the school; this aid will be available to the student as long as she attends the NHCS.

The evaluation process for the success of this pilot program focuses mainly on analyzing information from interaction with school and Infirmary officials. The key areas of interest include:

- the percentage of students who received needed follow-up care
- the Infirmary's communication process with the school and the parents, and
- ways the Infirmary can improve the testing and follow-up process

The Infirmary's main challenge continues to be follow-up care. It is difficult to ensure that students get the care they need, but they are working with NHCS administration to improve this process. Next year, the program will expand to include all new students and perhaps additional schools. They hope to expand the scope of the program to also include an educational component and Infirmary tours.

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Massachusetts General Hospital
with Chelsea Healthcare Center and the City of Chelsea
Partners in Improving Health

Goal: To reduce the incidence and long term effects of youth violence in Chelsea on children, families and the community.

Target Population: Middle school age children who have witnessed violence, who have demonstrated violent behavior and/or who are at high risk of acting out violently.

Description: A little more than two years ago, MGH-Chelsea Healthcare Center and MGH Community Benefit Programs engaged with the community to determine and collaborate on key health issues. As a gateway city for many immigrants, Chelsea enjoys the strengths of history and diversity – and faces educational, social, economic and health challenges common to recently arrived immigrants. A Chelsea Community Benefit Advisory Committee, formed with social service agencies, government, school, police and citizens, conducted a year-long community health assessment. As part of this, more than 120 people aired their views at a City Hall forum where testimony was simultaneously translated into four languages. At this forum, the community decided to address the issue of youth violence. (According to the Dept. of Public Health, Chelsea has the highest rate of weapons-related injuries in Massachusetts.)

While unique partnerships and programs have developed to address violence, there have been many additional "unintended positive consequences" of the process. In Chelsea, key players - particularly the City of Chelsea Health Department and MGH – have begun working together with new energy. These partnerships, which address everything from asthma to absenteeism, are effective for making progress on issues which aren't relegated to one domain, but can affect the whole community.

Police Action Counseling Team (PACT). Every Saturday night in Chelsea, an MGH-Chelsea psychologist or licensed clinical social worker spends an eight hour shift riding with Chelsea police in a squad car to intervene with child witnesses or victims of violence. The team is also available 24 hours, 7 days per week on call. The goal of the program is to help children and their families deal with trauma by intervening on the scene, teaching parents about the effects violence has on children, getting children into medical care when appropriate, connecting families to community resources, and making follow-up visits as needed. To date, PACT has served over 60 children.

Coordinating Committee. Comprised of youth serving agencies and officials in Chelsea (social service and youth agencies, schools, police, city government, DSS and MGH-Chelsea HealthCare Center), the Committee meets regularly to share information about individual children identified as being at high risk. The goal is to create a

comprehensive plan to intervene on behalf of the child and family. Periodically the Committee assesses trends and makes program and policy recommendations.

HAVEN (Hospitals Helping Abuse and Violence End Now). In the first year of this hospital wide domestic violence program, 20% of referrals came from the Chelsea community. MGH assigned a full-time domestic violence advocate to the Healthcare Center to provide support, counseling, referral, safety planning and other services to victims of domestic violence and their children.

School Health Collaborative. MGH-Chelsea, the Chelsea Health Department and the Chelsea Schools are working together in an innovative outreach program to support school nurses, reduce absenteeism, and better address the medical needs of the 5000 children enrolled in the Chelsea Public Schools. The Health Department found that school children and their families often lacked health insurance, and faced linguistic and cultural barriers to utilizing available services. The City proposed to create a concrete link between the school nurses, the Health Department and the MGH Healthcare Center by creating a team consisting of a public health nurse and two bicultural, bilingual outreach workers. The team's mission is to work with clinicians, principals, and school nurses to identify and refer families and children within the school system needing services, address barriers to access, provide care management in schools and the community for chronic health problems, and enroll the uninsured in public insurance programs. MGH Community Benefit program funds this effort. Partners Healthcare System has also been involved by providing a computerized case management software tracking system and program evaluation to measure both process and outcome indicators. To date, the outreach team has helped to resolve more than 80 cases with all partners actively engaged in the implementation of the program.

The lessons of this program are replicable in other school and public health nursing programs serving medically underserved children in urban school systems. It demonstrates how medicine and public health can collaborate around mutual concerns. Through a link team in the school, primary care can reach children and their families where they are, and schools can reduce excessive absenteeism from chronic conditions, such as asthma, and ultimately improve children's ability to learn by insuring that they are as healthy as they can be.

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Milton Hospital*

Milton Inter-agency Network for Elders, Inc. (MINE)

Goal: To serve as a unified agency dedicated to Milton's senior citizens and their loved ones, to act as a resource, and to identify unmet needs of this elderly population.

Target Population: Senior Citizens

Description: MINE is a nonprofit coalition of agencies formed in 1997, which values and serves seniors through its unique and dedicated services. MINE's purpose is to encourage not-for-profit organizations to focus on senior issues, and support programs suited to the elderly in Milton. The elderly make up approximately 20 percent of Milton's population.

MINE is composed of the its sponsoring organizations (see next page), including representatives from each, and an elected board of directors. The board of directors and committee members meet monthly to plan new programs. After assessing the needs of the seniors in Milton, MINE has established three areas of concentration:

- transportation
- education
- loneliness/isolation

In just over a year, MINE has created and supported a variety of services for its elderly population. The Milton Council on Aging has volunteer drivers who provide transportation to and from doctor's appointments, the supermarket and other shopping centers, Monday through Friday. Milton has three vans available to transport the seniors. The town of Milton pays for gas and maintenance of the vans, and the drivers are funded solely by private donations, often not enough to cover the cost of employing drivers.

In 1997, MINE spearheaded a letter-writing campaign to the town meeting members with facts and figures about financing rides for seniors in order to elicit support and funding to pay part-time van drivers. The initiative received majority support from town meeting members, and produced enough funds to employ one part-time van driver.

In addition to that service, the Council on Aging offers many programs, including a widowed persons support group, a book club, a pilot computer program and a nutrition program.

The Milton Police Department has an enhanced 911 emergency calling system, which can dispatch an ambulance, the police or the fire department to the home of an elderly resident immediately. They also offer Project I.D.; this is a bracelet program designed to assist seniors and their families with medical emergencies. Seniors may register for the program at the Milton Police Station.

Milton Hospital offers an extensive Community Education Series targeted mainly to the senior population, including lectures, forums, screenings and workshops on a variety of

topics such as Prostate Cancer, Alzheimer's Disease, and How to Prevent Slips and Falls. A list of all the programs offered can be found in the hospital's "ON CALL" calendar, which is published biannually with the "ON CALL" newsletter. The newsletter and calendar are mailed directly to residents's homes.

In addition, the hospital and the Council on Aging offer many volunteer opportunities and strongly encourage seniors to become involved.

One of MINE's newly-formed subcommittees focuses on the loneliness/isolation of Milton's elderly residents. The idea for a Friendly Visitor Program is in its earliest stages, but MINE has already begun to contact local churches, and anyone else who will listen. Friendly visitors would check on seniors who live alone, either by home visits or regular telephone calls. The plan is to make sure that the elderly have contact with someone every day. MINE plans to work in conjunction with the transitional care unit at Milton Hospital so they will know when a patient has been discharged.

A couple of months ago MINE held a spring conference "Aging in America," at Milton Hospital's Nangeroni Education Center. It focused on senior issues, as well as concerns and problems facing the sandwich generation, who are people that still have children to raise, as well as elderly parents to care for. Over 100 people attended this first of three inter-generational conferences held by MINE.

It was at this same conference that MINE handed out a guide, detailing Milton's community resources for seniors, to all participants. Milton Hospital donated the funds to print the guide and dedicated personnel to compile and computerize the information. MINE published the guide, which gives a background, location and brief description of each of the MINE agencies. This handy booklet is made readily available to Milton seniors.

Because it is a nonprofit organization itself, MINE does not have the budget to advertise its services. It relies heavily on word-of-mouth, articles in the local newspapers, and frequent feature stories in Milton Hospital's "ON CALL." Even so, in the year since its inception, it's no secret that other towns have seen that MINE has made major strides toward providing quality care to Milton's elderly, and have begun forming their own similar programs.

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*** In close association with Milton Council on Aging, Milton Police Department, Milton Residences for the Elderly, Milton Visiting Nurses Association, Cooperative Elder Services, South Shore Elder Services, Fallon Ambulance, Milton Health Department, Milton Public Schools, and Milton Public Library.**

Morton Hospital and Medical Center

Taunton Student Health Corps

Goal: To provide primary and preventive health services to uninsured, underinsured and linguistically isolated area residents through qualified nurse practitioner students, graduate nursing students and community health education students.

Target Population: The target population includes residents of the greater Taunton area (Taunton, Raynham, Middleboro, Lakeville, Berkley, Dighton, Rehoboth, Norton, Mansfield and Easton) who lack health insurance, are underinsured and/or lack access to primary health services.

Description: The Taunton Student Health Corps was first conceived in the fall of 1996 as a pilot program of the Health Education Learning Partnership of Massachusetts (HELPMASS) legislation filed by state senator Marc Pacheco. In late 1997, the program began with funding from the federal Americorps program, State Department of Public Health and Morton Hospital and Medical Center.

Student Health Corps members provide primary care, health promotion and disease prevention services in community settings where residents live and work, including area businesses, civic organizations, churches, councils on aging, housing authority sites, schools and shopping malls. Services are customized to meet the needs of each target group and may include clinical services, disease management, wellness programs, illness and prevention services, education about healthy lifestyles, and health screenings and assessments. To date, this program has served approximately 4,400 residents.

In 1995, the Greater Taunton Health and Human Services Coalition commissioned a Community Needs Assessment with a professional market research firm. The process included:

- analysis of population, demographic and socioeconomic trends and statistics
- a representative survey of greater Taunton area residents (including "hard-to-reach" populations, estimated to be about 10,000 individuals)
- a mail survey of health and human service providers, physicians, clergy and human resource directors at businesses and agencies serving the greater Taunton area
- and interviews with key business and political leaders.

This survey noted several relevant trends:

- Educational levels of greater Taunton area residents had not kept pace with current employment trends, and resulted in unemployment higher than the state average
- Rapid population growth in greater Taunton was putting pressure on health and human service providers
- Significant numbers of families and individuals were living in poverty or near poverty; approximately 14% of area adults (over 7000 residents) were without health insurance (26% of "hard-to-reach" residents surveyed)

- Access to health care was a problem for many residents surveyed – barriers cited included lack of insurance, lack of physicians accepting MassHealth, lack of transportation, and inconvenient office hours.

To address the needs revealed through this survey, the Taunton Student Health Corps members became involved in the following programs:

- providing nursing coverage for a YMCA camp in Middleboro attended by 300 children
- providing blood pressure checks, health assessments and teaching to seniors at the Dighton Council on Aging and other area senior centers
- coordinating a health fair for residents of a Taunton Housing Authority site
- providing screenings and health education teaching to residents at a second Taunton Housing Authority site
- providing nutritional counseling to patients living with HIV/AIDS
- providing screenings and health assessments to residents utilizing services at a local soup kitchen
- revising a "Teen Topics" prevention curriculum with the local teen pregnancy prevention coalition
- making home visits to conduct teen/family assessments of new teen mothers with representatives of the local Young Parents Program.

Program implementation was delayed until January 1998 because area nurse practitioner programs had already assigned students to clinical rotations. Nurse practitioner students require a one-on-one relationship with a clinical preceptor (physician or certified nurse practitioner). The program director spent numerous hours developing relationships with potential preceptors in the greater Taunton area and educating them about Americorps and the Taunton Student Health Corps. By January, 1998, 17 Taunton Student Health Corps members had been recruited and placed with preceptors.

Three sites are being used to deliver clinical services to underinsured and uninsured area residents: Taunton Family Medicine -- a hospital-affiliated medical practice located in downtown Taunton -- and school-based health centers run by Morton Hospital, located at the Taunton High School and East Taunton Elementary School. The goal is to provide access to primary and preventive health services for up to 5,760 uninsured and underinsured patients through these facilities. Taunton Student Health Corps members are also beginning to build relationships of trust with "hard-to-reach" populations in the greater Taunton area, laying the ground work for improved service delivery. Health Corps members are working steadily to develop host sites for service delivery (15 sites to date), and to identify uninsured or underinsured residents and arrange for needed services.

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Mount Auburn Hospital/Care Group

Watertown Community Health Improvement Program (W-CHIP)

Goal: To identify stakeholders from across the community, gather data and identify and prioritize health issues, and implement one or more health interventions in collaboration with multiple agencies within the community.

Health Problem: Lack of coordination among local health improvement efforts.

Description: In 1996, Mount Auburn Hospital and the Watertown Health Department, with assistance from the Center for Community Responsive Care (CCRC), initiated a community health partnership to develop Watertown as a "healthier cities" community. The goal of this effort was to establish an ongoing planning mechanism, in collaboration with the Watertown community, to identify public health needs and to develop interventions to improve the health status of Watertown residents.

After completion of an extensive needs assessment process (described below), Youth Risk Behavior was identified as the area of greatest need. In June 1997, a sub-group made up of teens and teachers from the high school and other interested people initiated a club known as W-HAT (Watertown Healthy Acting Teens.) The overall goal of this effort was to identify areas of greatest risk and develop interventions to lower youth risk behavior in Watertown. W-HAT members were trained by a community physician in epidemiological theory and practice, and subsequently developed and performed a survey based on the 1997 Massachusetts Youth Risk Behavior Survey.

Goals for next year include:

- Publish and distribute survey results
- Incorporate W-HAT into the Health curriculum for several classes at the high school
- Develop interventions based on areas of highest need identified by the survey results
- Develop an ongoing survey process to measure the results of the interventions
- Continue to have youth play a major role in the decisions and actions of this effort

A second project, Watertown CARES (Community Access to Resources, Education and Services) was initiated early in 1998, based on the second priority area, Access to Services, which had been identified through the needs assessment process. Goals for this project for the next year include:

- Develop and publish a list of subject area experts in all identified areas of need for underserved and vulnerable populations
- Work with subject experts to ensure that they stay current on resources, education and services available, and provide this information as needed to requestors
- Identify additional innovative mechanisms for making the subject expert list more available to town residents (WEB sites, library databases, public information kiosks).

The needs assessment process upon which these interventions were based was Community Oriented Primary Care (COPC) model. The goal of this process is to involve all sectors of the community as equal partners in the collaborative health planning process.

100 representatives and leaders from the community met on a monthly basis for about a year. After conducting the community assessment, this group identified its top public health priorities as Youth Risk Behavior, Access to Services and Adult Risk Behaviors.

Of interest is the collaboration among Watertown's three major health providers and the local Board of Health. Mount Auburn Hospital, Harvard Vanguard and Tufts Health Plan all have interests in this community. All three, along with the Watertown schools, worked together as the largest supporters of the W-CHIP effort in Watertown. Mount Auburn Hospital provided staff support to the effort for 2 days a week and also provided office space and mail services. A doctor at Harvard Vanguard was a driving force in the effort to get W-HAT going and provided a significant portion of the training to the participants. A researcher from Tufts Health Plan has performed the bulk of the survey analysis for the effort. In this day of competition between health care providers, this is a real example of collaboration and has resulted in a very successful project at a very minimal cost.

Expected effect of the W-HAT program on the high school population is two-fold. The primary expected effect is the lowering of youth risk behavior by teens in Watertown as a result of interventions that will be initiated based on the survey results. The secondary expected effect, which is already evident in the students who participated during last school year, is the increased knowledge, competence and confidence evident in those students through their lessons and interactions while participating in the effort.

Watertown CARES also foresees two effects on its target population. First is the improved ease with which they will be able to access needed resources in the town. Second, it is our hope that we will expose any gaps in service as a result of this effort, and initiate actions to lessen or eliminate these shortcomings.

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Neighborhood Health Plan

Family Violence Prevention Initiative

Goal: To implement a violence prevention program for 100% of NHP's primary care providers, and as many other community-based organizations as possible.

Target Population: providers and other staff at any community-based organization needing training or assistance.

Description: Neighborhood Health Plan's *Family Violence Prevention Initiative (FVPI)* gives primary care staff the information and training they need to safely intervene in or prevent patients' domestic violence situations. Staff learn what to look for, how and when to ask, what to say or not say, which legal issues to be aware of, how people from different cultures and populations might respond, and where to refer patients for additional help.

In January 1997, NHP surveyed community health centers (CHCs) in Massachusetts on the range of domestic violence programs currently in place at their sites. The response rate was 54%. The study found that:

- Wide variation existed in development of programs at CHCs, with some sites reporting well-integrated and expansive programs and others at the earliest stages of development
- Estimates of domestic violence among CHC patients ranged from 0% to 65%, with a mean of 29%. Several sites estimated 0-5% prevalence; since previous research shows that the prevalence of violence nationally is much higher, this estimate suggests the need for education about prevalence of family violence and identification of victims
- Over half of responding sites reported they had no formal written protocol for domestic violence; of interest, sites with female administrators were more likely to have protocols than those with male administrators
- 28% of sites offered no training sessions for providers on domestic violence during the prior 12 months; only half reported presence of advocates, though most sites (65%) reported some form of partnership for domestic violence with another CHC or community agency
- 65% of respondents had not participated in any prevention programs during prior year

NHP held a focus group in February 1997, involving 14 CHCs and 4 hospitals. Participants wanted help with the following:

- creating an organizational framework to approach violence as a health issue
- protocol development and implementation; ways to address issues of safety for providers and patients at sites
- information on chart documentation and legal issues for staff
- culturally-sensitive training on screening and intervening for domestic violence, including ways to reduce barriers to clinician involvement

Neighborhood Health Plan took the following steps to establish the *FVPI*:

- Assessed the range of family violence programs in place at Massachusetts community health centers (See above.)

- Established in February 1997 an Advisory Committee representative of Massachusetts' communities to help guide NHP's family violence initiative
- Assisted community health centers and other providers in responding to family violence by developing and distributing a comprehensive *Family Violence Resource Manual* for primary care providers. This is the cornerstone of NHP's initiative. Over 500 copies of the *Manual* have been distributed
- Developed a mechanism for providers to share information about family violence through NHP's *Violence Prevention News* newsletter. *Violence Prevention News* debuted in Fall, 1997; 4 issues have been published
- Sponsored training sessions for clinicians on screening and effective interventions for individuals experiencing family violence. Over 30 training workshops have been conducted with more scheduled to occur through December 1998 and beyond
- Established a mechanism in 1998 for providers and domestic violence advocates to enhance professional skills through an annual NHP Domestic Violence Advocate Scholarship program

The initiative is focused primarily in Massachusetts; however, the protocols in the training manual can be used in almost any primary care setting. NHP had originally focused its resources on the development and distribution of the comprehensive *Family Violence Resource Manual*, working with the author, Annie Lewis O'Connor, a nurse practitioner at Neponset Health Center and a domestic violence survivor herself. The *Manual*, published in 1997, includes more than 300 pages of information and protocols for primary care providers. Twenty manuals have been distributed nationwide.

While the *Manual* was extremely helpful, more hands-on assistance was needed, particularly for fledgling programs. In early 1998, NHP implemented a series of training sessions. The training assists CHCs with using the *Manual* effectively and building or expanding the scope and effectiveness of their intervention and prevention programs. Five hundred fifty providers had attended NHP-sponsored training sessions as of September 1998.

The Family Violence Prevention Initiative incorporates community collaboration throughout the program. The Advisory Committee includes representatives from a variety of community organizations, including community health centers, medical groups and the Boston Public Health Commission's Domestic Violence Prevention Initiative. The family violence training also provides a link to the community by involving many different community groups. Training has occurred at Alliance for Young Families, Massachusetts League of Community Health Centers' Women & Child Health Access Project, Family Health and Social Service Center, Visiting Nurse Association of Boston and several community health centers.

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New England Medical Center

Asian Health Initiative

Goals: NEMC and the Chinatown Neighborhood Council seek to identify barriers to health care for the Asian immigrant community, develop programs and services for public health care needs, build a stronger public health network within the Greater Boston Asian American provider community, and recommend policy changes to improve the delivery of patient care services.

Target population: Asian-American immigrants.

Description: Asian Americans remain a population experiencing difficulties in consistently accessing adequate health care. Cultural beliefs, language barriers, and health insurance coverage contribute to the phenomenon of refraining from utilizing the U.S. health care system. Health care providers have seen increasing manifestation of illnesses inherent in this population that require early attention and regular treatment; diseases such as Hepatitis B, Tuberculosis, Hypertension, Diabetes, and Lung Disease are highly prevalent in the Asian immigrant community.

Three years ago, members of NEMC's senior management and representatives from major social service, human service and health care providers in Chinatown combined to form The Asian Health Initiative (AHI) Committee. The AHI Committee meets periodically with internal NEMC departments to receive progress reports on various programs within the hospital and provide input to improve delivery of care across cultural and linguistic boundaries. As a result of these interactions, NEMC has put in place a number of programs to make the hospital more hospitable to immigrants. These efforts include cultural education workshops and seminars for the staff, increased hiring of bilingual providers at different departments, installation of multilingual signage, maps, and phone lines, and monthly educational forums to familiarize patients with the U.S. health care system.

On the public health front, the AHI Committee invites community medical providers, social workers, counselors, and staff from the State and City Health Departments to join in regular round table discussions to identify prevalent community health issues. To follow through on these efforts, NEMC elicits and funds program proposals from the community through a competitive bidding process.

NEMC and the Asian Health Initiative prioritized and secured funding to address the following public health initiatives:

- 1996-1998 Hepatitis B/Tuberculosis Education and Outreach Campaign, run by the Asian Health Collaborative (a collaboration of five major Chinatown-based agencies). Achievements: Trained 20+ staff at these agencies to do public health outreach. Sent Outreach materials 3000 seniors. Newspaper articles on health topics reached 7000+. 350 teens and young adults received health information. 100 high-risk individuals attended workshops. 68 adult new immigrants attended Job Training with health information incorporated into the curricula. The five agencies have moved on to the second year with an additional focus of primary care and prevention.

- 1998-1999, a six-agency collaborative was selected to conduct Chronic Disease Prevention Education and Outreach targeting common and preventable diseases in the community. Agency staff will receive public health training and will present and promote their acquired knowledge on adoption of healthy behaviors, modifications of social norms related to nutrition, physical activity and tobacco use. The combined effort of the six agencies will reach 10,000 people through general outreach, and serve 1,300 people through targeted activities such as educational presentations, screening and follow-up services.
- 1998-1999, the Hepatitis B Collaborative, managed by a coalition of students from Harvard and Tufts, have also received funding to continue their creative outreach to the high-risk Asian American youth population. The goal is to educate, screen and vaccinate 500 Asian youths by spring of 1999.
- 1998-1999, a Request for Proposals has been issued for the development of culturally sensitive and linguistically accessible Primary Prevention Education Programs on Family Violence in the Asian Community.

The intent of NEMC in investing in community public health programs is to begin to build a broad network of health educators who through their jobs or community connections, can effectively reach new immigrants on health issues with information that will be useful to them.

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Newton-Wellesley Hospital

CEO Challenge: Partners Against Domestic Violence

Goal: To aid victims of domestic violence through support of The Second Step, Inc., a transitional home.

Target Population: Victims of domestic violence.

Description: The *CEO Challenge* is a partnership between Newton-Wellesley Hospital (NWH) and The Second Step, Inc. (TSS), a transitional home for victims of domestic violence and their children. Started in 1995, this partnering of corporations with battered woman shelters derived from the Governor's Commission on Domestic Violence. Polaroid Corporation brought it to fruition. NWH was the first corporation to undertake this unique alliance.

At first glance, the fit between the two different organizations and missions was not apparent. However, as the top organization leadership came to understand the community need and visited the residents of the shelter, the commitment grew. Hospital employees donated holiday gifts, food, and clothing. The residents of TSS helped the Hospital identify with their needs and understand domestic violence.

Over the past four years, Newton-Wellesley Hospital has provided a wide range of services for TSS and its residents. These include: stress management, smoke cessation, renovation of the children's playground and shelter, moving furniture for the residents, provision of medical care for the adults and children, and a health promotion program through a certified nurse practitioner. In addition to health education classes, preventive services are provided, i.e. immunizations, family planning, cancer screenings, and nutritional support.

The goal for the Hospital is to ensure that TSS remains a viable community asset, and to improve the health behaviors and environment for the residents. TSS, on the other hand, provides the NWH with consultation services on matters pertaining to domestic violence. For example, they advise the Hospital's educational programs and clinical services that focus on victims of domestic violence.

The shelter can house eight adults and 13 children from anywhere in Massachusetts. Since opening in 1993, TSS has provided services to 57 women and 84 children. Forty-four (87.5%) of the TSS "graduates" are self-supporting. TSS now has a three family home (Garfield House) as a step-down facility following a stay at the shelter. The residents can remain at the shelter up to one year.

The Community Benefit Committee at NWH assessed the health needs of its community (health statistics, focus groups, surveys, literature review) through several

venues. Health goals were established in FY 94 with domestic violence at the top of the list. A domestic violence initiative started with the establishment of a Hospital Domestic Violence Prevention Council, complemented by a Domestic Violence Advisory Committee. The Committee was comprised of a diverse group of community stakeholders. Further, NWH played a prominent role in local domestic violence discussion.

Thus, the Hospital had information on community needs relative to domestic violence from a variety of internal and external sources. We learned from the Massachusetts Coalition of Battered Women Service Groups that in recent years more than 1,400 women and nearly 2,000 children were turned away from shelters due to lack of space. This evidence was supported by one of the Health People 2000 Violent and Abusive Behavior Objectives (7.15): "Reduce to less than 10% the proportion of battered women and their children turned away from emergency housing due to lack of space". These health statistics, and the expressed needs of TSS pointed us in the direction of the *CEO Challenge*.

The Hospital collaborated through the Newton Domestic Violence Action Committee and the Community Health Network (CHNA 18). NWH also worked with the Support Committee for Battered Women Service Groups and the Mass. Coalition to support the sheltering system in the Commonwealth. These collaborations enabled the Hospital to identify TSS' needs, and other community domestic violence issues.

Since women and children living in violent situations are at increased risk of health problems, we were able to involve the Hospital medical staff in providing competent and sensitive medical care. Enhanced relationships between institutions and providers resulted. Other projects burgeoned as spin-offs from these relationships, i.e. Mentors in Violence Prevention (MVP Project).

The program is readily transferable to other organizations, keeping the following elements in mind:

- build awareness;
- gain commitment at the top;
- identify a project champion(s);
- set realistic goals.

Each organization in the partnership needs to establish an agreement from the outset in order to identify needs that are mutually beneficial.

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Noble Hospital

Westfield Community Health Committee

Goal: To identify conditions deemed detrimental to the health and well being of the citizens of Westfield, and, utilizing the collective advocacy of the committee and the community, to attempt to remedy or ease those conditions.

Target Population: The Westfield community.

Description: The University of Massachusetts School of Nursing did a Westfield Community Health Assessment for Noble Hospital in November of 1994. Substance abuse and children were identified as one of the needs within the community. The Westfield Community Health Committee reviewed this report and its conclusions. The committee also developed a list of 21 other community needs. The Westfield Community Health Committee formed in September 1996.

In September of 1997, the committee prioritized the list and selected drug/alcohol abuse as the initial project. The committee further refined the scope of the project by targeting middle school age children. The objective was to educate these students and their parents about alcohol and drug dangers. The committee was committed to working with the school department on this project. Our school department member contacted the middle school principal to work with us.

Working with the vice-principal of the middle school, we set the following objectives:

- Determine what the students knew about alcohol and drug use
- Determine student use of alcohol/drugs in middle school students

A student survey was selected to determine a baseline for this information and as a benchmark for continued planning. The survey was administered to the 5th, 7th, 9th, and 11th graders. The survey allowed students to "self-report" alcohol, tobacco, and other drug (ATOD) use; perception of the harm of specific drugs; availability of specific drugs; availability of ATOD; "at risk" behaviors; and personal safety/violence issues. In conjunction with the school's Safe and Drug-Free Schools program, these data are intended to assist the schools and community in identifying health and safety issues among students and to develop strategies to address them.

This initial survey was done in the spring of 1998. This is a baseline survey to allow us to measure the effect of the community's efforts to educate children regarding the effects of drug and alcohol use. A second survey will be done in two years, again with the 5th, 7th, 9th, and 11th grade students.

The following categories of individuals are a part of, or are represented on the committee:

- Mayor
- Superintendent of Schools
- President of the College
- Chief of Police
- Health Commissioner
- Fire Chief
- Hospital President
- Chamber of Commerce President
- Clergy Association
- YMCA Chief Executive
- Senior Citizens
- Parent representative
- Latino Community representative
- Mental Health professionals
- Social Service agencies
- CHNA
- Mass. Prevention Center
- Citizens from the community

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North Adams Regional Hospital

NARH Community Benefits Program

Target Population: All of the residents of North Adams Regional Hospital's primary service area of North Adams, Adams, Williamstown, Clarksburg, Florida and New Ashford as well as residents of other Berkshire and Southern Vermont communities that comprise the community served by hospital.

Goal: We are committed in partnership with health and human service providers throughout our service area, to promote the physical, social and environmental health and well-being of our community through traditional and non-traditional programs that will lead to an enhancement of the quality of life for Northern Berkshire residents.

Description: The NARH Board of Trustees adopted a Community Benefits Mission Statement in 1996 that parallels the hospital's mission of improving the overall health status of the citizens of North Berkshire. The first allocation of community benefit funding was awarded to Ecu-Health Care, which provides access to health care for the uninsured, and to With Child, a program that provided services to young families.

In 1998, NARH began looking at being a proactive player in working to build a healthier community. The Community Benefits Program was geared on allocating resources to begin to create a true 'health' care system – one that focuses its efforts on helping people lead healthy lives. Health is no longer just about physical wellness or illness, but includes the social and environmental health and well-being of our community. A Community Benefits Advisory Group (CBAG) was formed to begin looking at health in an entirely different way. The CBAG reviewed the United Way's Lodestar Project data for our area to gain a further understanding of the community and our service area in particular. The CBAG focused on designing a standard application process to allocate resources to a broad spectrum of providers throughout the service area to encourage collaboration in improving the physical, social, and environmental health and well-being of the community. Traditional and non-traditional proposals were all encouraged in hopes that this shift would provide seed funds for some exciting initiatives, and assist existing programs.

For FY97 and FY98, thirty (30) applications were received from a diverse group of deserving programs, requesting over $300,000. After a great deal of consideration and discussion the CBAG was able to recommend ten (10) programs to the NARH Board of Trustees. The NARH Board of Trustees approved the recommendations and funds were awarded to the following:

ORGANIZATION	PROGRAM	FUNDING	DESCRIPTION
Berkshire Coalition to Prevent Teen Pregnancy	Wise Guys	$ 4,000	*To provide appropriate sexuality education to middle-school aged males.*
Berkshire Community Action Council	Dental & Prescription Assistance	$ 3,000	*To provide dental services and prescription assistance*
Berkshire Nursing Mothers	Lactation Consultation Services	$17,000	*To make lactation consultation services available to all breastfeeding families in the North Berkshire Area.*
Cooperative Childbirth Association	Prepared Childbirth Classes	$ 1,500	*To offer prepared childbirth education classes.*
Ecu-Health Care	Health Care Outreach	$ 6,000	*To promote access to all health care opportunities available to the uninsured residents.*
Friends of the North Adams Council of Aging	Osteoporosis Prevention Program	$ 1,053	*To reduce osteoporosis risk through exercise and nutrition, and to help older adults maintain independence and quality of life.*
NARH - Respiratory Department	Moms Against Asthma	$ 4,250	*To link primary caregivers of children with asthma with appropriate health care providers and to reduce emergent care needs.*
Northern Berkshire Community Coalition	Healthy Community Programs	$18,200	*To enhance coalition programs.*
VNA & Hospice of Northern Berkshire	Living Alone with Supportive Care	$10,000	*To provide direct support to the terminally ill*
Northern Berkshire YMCA	Older Adult Health Outreach	$10,000	*To provide comprehensive assessments of participants with health professionals and to practice multidisciplinary health/fitness.*

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North Shore Medical Center

AtlantiCare and The North Shore Medical Center: A hospital merger

Goal: To turn a hospital merger into a partnership with the community.

Target Population: Residents of Greater Lynn.

Description: Lynn is a community in need of services. One-third of all Lynn residents and 26% of Lynn children live in homes with incomes under 200% of the poverty level ($32,100 for a family of four). The city has the lowest primary care physician to patient ratio in eastern Massachusetts. According to the Massachusetts Department of Public Health, the city has high rates of teen pregnancy, substance abuse, and infectious diseases and low rates of prenatal care.

On October 28, 1997, the Massachusetts Public Health Council approved a merger of North Shore Medical Center – an affiliate of Partners HealthCare System – and AtlantiCare Medical Center in Lynn. The merger and its Determination of Needs (DON) conditions set a standard for Massachusetts hospital commitments to improve community health. The community process, led by the Lynn Health Task Force and the NSMC/AtlantiCare merger, not only ensures the survival of the hospital but will result in a comprehensive expansion of health services to the Lynn community.

The selection of NSMC as a merger partner by AtlantiCare was the culmination of a process of unprecedented community involvement. Following the release of a Request for Proposals, AtlantiCare hosted a meeting for the community and bidders to interact. Each of the four competing bidders provided an overview of what they would bring to health care in Lynn and answered questions from those in attendance.

The Lynn Health Task Force ranked each of the competing bidders and then held discussions with Partners HealthCare to clarify its community commitments. NSMC/Partners provided these clarifications in writing. The Task Force then informed the AtlantiCare Board of Trustees about the clarified and enhanced commitments made by NSMC/Partners. On April 24, 1997, the Board of Trustees of AtlantiCare voted to merge with North Shore Medical Center citing two key reasons for its decision: the hospital's preference to keep the care of its patients in local hands and the value of the NSMC/Partners community health commitments.

One example of keeping it local: the nine months since the merger was approved have made the AtlantiCare Board of Trustees much more reflective of the Lynn community. AtlantiCare established a process to address such issues as filling Board vacancies, holding public forums prior to electing Board nominees and other methods to increase community input into the Board's composition. As a result of this

collaboration with the Lynn Health Task Force, the AtlantiCare Board of Trustees is more diverse and more reflective of the Lynn community:

Before the merger	After the merger
12 members	22 members
(11 men and 1 woman)	(15 men and 7 women)
No minorities	6 minorities
4 Lynn residents	13 Lynn residents (or close ties to Lynn)

The work of the past year has gone a great distance to bring about true collaboration between NSMC/AtlantiCare and the community. Currently, representatives of the hospitals and the community meet monthly to discuss general issues as well as conduct frequent meetings to focus on specific program matters. Much progress has also been made in meeting the DON requirements of the merger agreement, including:

- Hiring two community outreach workers to assist patients in applying for publicly funded health insurance and improve uninsured patients' access to care. (One of these outreach workers, a Khmer woman, is a new member of the AtlantiCare Board.)
- Hiring three full time medical interpreters (Spanish, Khmer, Russian) and initiating 24-hour interpreter coverage.
- Funding a new clinic at Breed Middle School in order to promote and improve routine primary care as part of adolescent health.
- Working with the Lynn Community Health Center to finalize an affiliation agreement to provide capital support and operating revenue in order to expand primary care services.
- Establishing a primary care walk-in service on Boston Street in Lynn.
- Funding two domestic violence counselors through the HAWC program who will be stationed at AtlantiCare and Salem Hospital.
- Funding two adult counselors at Girls, Inc. to provide information and support around the problem of teen pregnancy.
- Maintaining a free van service, with the addition of four stops at senior citizen apartments, and beginning a process to look at complex transportation problems for AtlantiCare patients.
- Funding expanded services at Crossroads, an HIV counseling and support center.

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Quincy Hospital

Asian Task Force

Goal: To identify health care issues faced by the Asian community and develop a plan of action to bring together resources to address these issues.

Target population: Asian population throughout the South Shore.

Description: In 1995, Quincy Hospital gathered more than 23 leaders from the Asian community including representatives from the Asian American Service Association (AASA); Quincy Asian American Association(QAAA); Immigrant & Refugee Committee in Quincy; Wollaston Lutheran Church; Chinese Baptist Church of Greater Boston in Quincy; local Asian physicians; medical providers who serve the Asian community including Manet Community Health Center; and city officials, including the Police Department. The Task Force has helped identify and address the most pressing health care needs of local Asian residents. The hospital's Program Director of Asian Services has served as the leader of the ongoing group since its inception.

The project began with the group brainstorming about their concerns and then ranking their top three issues. Ultimately, they decided that the Task Force and the hospital should focus on improving access for the Asian community, offering health education and prevention, and identifying needed health care services. The Task Force then identified three specific projects for each of these priorities that they could undertake with the hospital. The result was nine different projects that have been implemented over time.

As the group sought to improve access for the Asian community, there were efforts undertaken to hire more Asian staff, create a more user-friendly environment, and improve transportation. The most difficult project has been hiring more Asian staff, and there is still a strong focus on increasing our numbers in that area. A number of initiatives were implemented to make the hospital more user-friendly. Quincy Hospital installed a new signage system with Chinese translations, and maps were translated into Vietnamese and Chinese. The hospital has also translated numerous brochures and important materials into Chinese and Vietnamese. Binders have been placed in each of the patient units to help staff as they work with Asian patients. The binders include how to access interpretation services, some key phrases to use with patients, and information about available resources. The hospital also extended the hours of free shuttle bus transportation from the T-station to the hospital and widely publicized that within the Asian community. The hospital also develop a Asian menu that offers traditional dishes for the Asian community.

In its efforts to enhance health education and prevention, the members of the Task Force have provided input on various topics that can be presented to the community to help improve health. The first topic focused on *How to access the U.S. Healthcare System*. Over the past three years, more than 1,000 people have heard

presentations on home safety, emergencies, raising children in a different culture, the safe use of medicines, and accessing the U.S. health system. The hospital organizes a free annual "Healthy Holiday Party" for the Asian community to screen blood pressure, glucose, cholesterol, provide an eye and oral exam, and a physical colorectal exam. In 1997, over 1,000 Asians attended the party.

The group has discussed needed health care services. There are several primary care practices in Quincy that serve the Asian population. The greatest need seems to exist in providing specialty services on a local basis. The greatest challenge is the health insurance status of many of the Asian residents and their long-standing relationships with in-town teaching hospitals where they can receive free care services. We continue to study this situation to determine if we can enhance services offered locally. We have received funding to provide free mammograms and pap smears for uninsured women, and this program is being established this year.

Quincy Hospital has worked closely with the leaders of the local Asian community to ensure that we are working to meet their health care needs.

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Saint Anne's Hospital

Hope House

Goal: To provide permanent housing for people with intermediate and end stage AIDS.

Target Population: People with HIV and AIDS who are homeless.

Description: In September of 1994, Saint Anne's opened Hope House for persons with mid to end stage AIDS. In the early 90's, many in the community and at the federal and state level were aware that a growing number of persons with AIDS were barely subsisting, or dying, on the street, in temporary shelters, or in dangerous drug houses. Through a collaboration of these groups, Saint Anne's established Hope House by obtaining more than $500,000 in grants and low interest loans. Hope House can shelter up to ten people and provide them with nursing care, psychological support, meals, and transportation in a homelike residence near the hospital. At its opening in 1994, it was the only such residence in southeastern Massachusetts, and remains the only one in the Fall River area that will accept individuals at mid to end stage AIDS. Hope House has serviced some 56 residents since its inception, with 32 dying and the remainder either living at Hope House or going on into the community to live with this illness.

Hope House receives ongoing support from the Hospital for close to 50 percent of operating costs – over $206,000 annually. Grants from the Massachusetts Department of Public Health provide for the balance of costs for staffing. Hope House is a place of peace, renewal, and reconciliation for persons who literally have no place else to go.

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Saint Vincent Hospital

The GUTS Program (Growing Up The Strongest)

Goal: To provide alcohol, drug and violence prevention education to minority and low income teenagers.

Target Population: Worcester's minority and low income youth.

Description: Aimed primarily at substance abuse and violence prevention, the GUTS program, sponsored by the Henry Lee Willis Community Center, trains a performing arts team of multicultural youth. The children, ages 14 -18, create and perform songs, raps, skits, game shows and talk shows that provide alcohol, drug, and violence prevention education to predominantly minority youth throughout Worcester, especially in low income neighborhoods. The performances occur in both traditional and non-traditional settings.

In 1992, the hospital worked with the DPH to determine which programs to fund as part of its Community Linkage Program, associated with the DON process. In 1996, due to the cessation of one of the linkage agencies, a total of $120, 978 became available to fund a new program. Given the change in some of the health indicators over the years and with the support of several community leaders and the local CHNA, it was determined that these funds support minority youth programs in the community. Hence, in November of 1997, Saint Vincent Hospital issued an RFR to the Worcester community for programs targeting minority youth.

Working with the Steering Committee of the local CHNA, over 20 responses from community agencies were critiqued, and recommendations were made to the hospital. The GUTS program, one of six to receive funds, rated the highest and received a total of $35,000.

Sixteen youth were recruited to serve as the cast for the GUTS program; 60% were Latino and 40% African American with 60% female and 40% male. Ages ranged from 13 to 18, with 60% of the young people on welfare. Additional statistics included 66% female single parents, 30% married and living together, and 4% living on their own. The participants had previous problems with substance abuse, dropping out of school, diagnosed learning disabilities and criminal activity.

Fourteen performances were given throughout Worcester with 1,749 individuals participating in interactive performances addressing teen pregnancy, HIV/AIDS, Race Relations and Violence. Audience members ranged in ages from 15 - 48 years old; 54% were male, 46% female.

Evaluations for the youth involved in the cast were conducted through personal interviews, home visits and assessments, and other resources. The results were as follows:

- all that had dropped out of school had re-enrolled
- referrals were made for counseling, emergency food and clothing, housing assistance and translation services

- half of the youth reporting substance abuse were engaged in treatment

Evaluations for the individuals attending the performances involved post-performance feedback. The results were as follows:

- 99% reported that it was helpful
- 100% reported that it was easy to understand
- 90% reported that they liked it

In addition, the Worcester Juvenile Court made five referrals to the program as part of Community Service required for restitution. All youth referred completed their hours by participating in the program.

Below are several comments made by youth members of the cast:

- We can't change the world but we can change how we deal with situations
- I feel like I don't want to hang around with the same people anymore (5 reported this)
- The GUTS kids support me and challenge me
- We have options and choices we didn't know we had
- It helped me to get out of the gang I was in (2 reported this)

Below are comments made by participants of the program:

- I didn't think that positive things could come from negative experiences
- These topics can happen to anyone
- I never knew people understood

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Southcoast Hospitals Group

Responsible Attitudes toward Pregnancy Prevention (RAPP)

Goal: To enable teens to make informed choices with regard to pregnancy prevention and sexuality, and to understand the potential effects of early parenthood on their life goals, social life, and future financial stability.

Target population: Teenage children in Greater New Bedford.

Description: Instituted at the St. Luke's Hospital site of Southcoast Hospitals Group in the 1996/1997 academic year, *Responsible Attitudes toward Pregnancy Prevention (RAPP)* is an innovative teen pregnancy prevention program to address the high pregnancy rate in Greater New Bedford, and Southcoast areas. Determination of the need for *RAPP* was based on St. Luke's adolescent delivery rates and the Department of Public Health statewide statistics. The Program is an interactive, abstinence-focused, school-oriented program targeting 11-16 year olds but primarily focuses on 13-15 year old boys and girls. *RAPP* educates teens about their sexual responsibilities through the basics of reproductive physiology, decision-making and goal setting skills, the realities of pregnancy, labor and childbirth, and the responsibilities of parenthood.

Teens live the experience of parenthood through the use of an infant simulator (a computerized doll) which becomes their responsibility for a 72-hour period. In addition to the doll, teens must take a car seat, diaper bag, and stroller with them for a weekend parenting experience. The simulator cries at random intervals, and requires intervention on the part of the teenage "parent" around the clock. The dolls record what transpires between the doll and the "parent" including neglect, abuse and tampering. This information is downloaded for analysis when the doll is returned. This tool forms the keystone of the program, and focuses on helping teens to understand the consequences of early parenthood and its effect on their freedom and future. The interactive nature of the program draws teens in as active participants rather than observers.

RAPP is a genuinely collaborative effort. St. Luke's Family Education staff, obstetrical nurses, and local school health departments and students form a partnership in presenting and maintaining the program throughout the school year. Licensed obstetrical nurses train the school's health department staff to administer the program, and gradually pass the classes to faculty instructors while remaining in close contact. Hospital instructors also train a cadre of peer leaders to act as resources and mentors for their schoolmates, and communities.

Evaluation of the *RAPP* Program includes:

- a confidential survey to determine the participant's level of sexual activity at the start of the program
- a pre-test and post-test to determine effectiveness of education and comprehension
- anonymous evaluation of perceived effectiveness of the program and the instructor
- periodic evaluation of each instructor.

A new component of the program, *RAPP for Parents*, is a 14-hour workshop targeting parents of 11-13 year olds, providing the basics of sexual education to parents in a clear, easy to understand format so they can open a dialogue with their children. This component allows knowledge sharing and education to start in the home.

The 1997/1998 academic school year saw the expansion of *RAPP* from the pilot school to three additional area high schools. With the additional schools, program numbers doubled to approximately 850 participating freshmen and sophomores. In addition, Peer Leader numbers rose to 42. School instructors increased to 10 this year, and Hospital instructors increased to six in 1997/1998. The success of the program is obvious to us in many ways:

- increased post-test scores
- attitudinal changes
- student and faculty evaluations

Measurable outcomes are a few years away. Schools are tracking pregnancies, and are trying to develop a tracking tool for *RAPP* graduates until the age of 19. For now, we measure our successes one student at a time.

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South Shore Hospital

Raising and Educating Your Child in a Violent Society

Goal: To combat teen violence and help parents, educators and health care providers better understand how children can survive and thrive in today's increasingly violent society.

Target Population: Parents, educators, heath care providers

Description: Violent and abusive behavior is an issue that concerns communities all across Massachusetts. According to Healthy People 2000, a national campaign to make our communities healthier, the US ranks first among industrialized nations in violent death rates. More than two million people are injured every year in violent assaults. The incidence of violence – whether in homes, schools, or on the streets – shows disturbing trends. In reaction to this, educators, health care providers, and parents attended *Raising and Educating Your Child in a Violent Society*. This half-day educational forum, sponsored by South Shore Hospital's South Shore School Partnership for Health, addressed ways children can survive and thrive in today's increasingly violent society.

The forum's keynote speaker was Peter Stringham, MD, of East Boston Neighborhood Health Center, who addressed different types of violence and their impact on children and families. Stringham's comments were followed by six sessions that addressed such issues as playground aggression, teen dating violence, peer mediation, and techniques for diffusing escalating incidents. All attendees agreed that there is an urgent need for our communities to become knowledgeable about the problem of violence. The South Shore School Partnership for Health took a leadership role in addressing this serious problem.

The problem of violence in southeastern Massachusetts cannot be solved by working alone. The only way to combat it is to continue efforts of health care professionals, educators, and government and law enforcement officials. That is precisely the approach South Shore Hospital spearheaded with the Norfolk County District Attorney.

South Shore Hospital continued its efforts to tackle the problem of escalating teen violence when it co-hosted a youth violence prevention meeting with Norfolk County District Attorney Jeff Locke. Fifteen school superintendents representing communities throughout southeastern Massachusetts attended the meeting and learned how schools can prevent violence from happening by identifying students at risk of committing violent acts.

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Sturdy Memorial Hospital

Maternal and Child Health Education Series

Goal: To provide education and information for women

Target Population: Women and Families with Children

Description: The key element of the initiative includes programming that provides information, education and support regarding medically related issues to help women and their families maintain and improve their health. The programs include the following:

- Positive Discipline for Kids
- Nurse Midwives – Another Option for Childbirth
- Fibromyalgia
- Fertility Options
- Birth Order in Family Relationships
- Easy Meal Planning for Families
- Managing Children's Sleep Problems
- Children's Medical Emergencies
- Pre-menstrual Syndrome
- Time Management for Mothers
- Facts About Breast and Heart Health
- Osteoporosis
- Lead Poisoning in Children
- What to Expect in the First Year of Life
- Mothers & Daughters Workshop on Puberty
- Peri-menopause Management
- Infant Massage
- Massage During Pregnancy
- Menopause Support Group
- New Mothers Support Group
- Pregnancy Loss Support Group
- Childbirth Education
- School-based Education Program
- Baby-sitting Training and Certification Program

The need was identified in discussion with area physicians and service agencies, and formulated using market information. Priorities were established based on needs and concerns. The impact on the community is to share our expertise and to work to improve the health of women and children.

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Taunton State Hospital

Utilizing Art to Implement a Mental Health Anti-Stigma Program

Goal: To educate the public on mental illness in an accessible, non-threatening manner.

Target Population: Children, teenagers, and adults in Southeastern Massachusetts.

Description: Taunton State Hospital is a 175-bed, psychiatric hospital whose mission is to treat clients that have a serious and long-term mental illness. The hospital is part of the Southeastern Area Office under the auspices of the Massachusetts Department of Mental Health. Clients that are served are primarily from Southeastern Massachusetts, but any citizen from the Commonwealth can receive services from the hospital.

In fiscal year 1998, the Department of Mental Health implemented its *Changing Minds* campaign. This statewide public awareness program goal was to educate the public about mental illness and break down the stigma the public had regarding this disease.

A survey commissioned by the Department of Mental Health in 1997, by Opinion Dynamics Corporation (Boston Globe, June 1997) telephoned 400 Massachusetts residents to find out about their attitudes about mental illness. The survey found the public has lingering misconceptions:

- 38% believe that mental illness is the result of character flaws and personality defects
- 90% believe that there is shame attached to mental illness, which can keep sick people out of treatment
- 10% get information about mental illness from their doctor, 27% from newspapers, 22% from television
- Nearly 66% believe split personality is a feature of schizophrenia
- Half of the respondents report they believe 50-100% of mental illness is treatable
- 56% of the respondents have had a personal experience with mental illness
- Respondents who know a mentally ill person are somewhat concerned that they may contract a mental illness that those who did not know a mentally ill person

The hospital, aware of these findings from this survey, assigned Sanford Epstein, a hospital program manager, to address the issues. The hospital had specific goals in educating the public on mental illness and its stigma:

- To reach all age groups: elementary, teen, college and adult
- To be sustainable; more that a one-shot public education program
- To gain feedback and support from the community
- To be able to repeat this process with other groups and individuals

Elementary Age: Explaining mental illness to young children was a challenge, since this disease is abstract in nature and difficult to explain. Children often become afraid when they are exposed to messages about mental illness as images of a "crazy person" or "monster". This is often seen on television or in the movies. The hospital wanted to be invited by local

elementary schools to go and speak to a class about it. Two were contacted and one accepted our invitation for us to sponsor a poster contest during National Dietary Month. Prizes were donated by The Friend's of Taunton State Hospital. Students submitted their pictures, which were hung in our Client Cafeteria. The Dietary Director judged them and the Chief Operating Officer, Dietary Director, and Sandy Epstein presented prizes for the poster chosen, and spoke about mental illness and the hospital's function. Forty second grade students at this Taunton school participated in the event. The principal and teacher asked the hospital administration to come back next year and possibly add a grade to the contest.

The other elementary school project was the implementation of the *Kids on the Block Program*, an internationally known program in which life-sized puppets with specific scripts act out issues of mental illnesses which children may face. One show was on Attention Deficit Disorder and the other on emotional difficulties. A professional was available after the show to answer questions from the children on mental health issues. Scripts are written for children third to fifth grade. A local high school 4-H puppeteer group was recruited to be puppeteers. The Parent Information Network (DMH Vendor), and the hospital were co-facilitators of the activity. Shows were done at the Taunton and Middleboro Public Libraries. Plans for future shows are to be presented at the Dighton Public Schools this Fall and the Big 'E' multi-state fair in September.

Private Art/Public Institution Program: During an inspection of the hospital a year ago, comments were made that specific internal walls of the hospital were dull and unattractive. The Private Art/Public Institution Program was created to attract schools, groups, and individuals to improve the environment at the hospital. Artists were solicited to paint murals, donate their pictures, quilts, etc. This was done through networking, correspondence with art departments in schools, artist guilds, and public service announcements. If artists were interested in creating original pieces, The Friends of Taunton State Hospital and /or the hospital canteen fund bought specific art supplies to create these pieces.

Projects Commissioned to Date:

Group/Type	Piece
The Educational Cooperative High School	"For Every Season There is a Turn"
15 Students, artists in resident mural	(seasonal mural)
Cohasett Senior Art Class 3 Students, art teacher	"A Sea of Tranquility" (ocean mural)
Wheaton College 1 Student, art advisor	"A View from the Terrace" (mural)
Adult Donor; Falmouth, MA	"The Chameleon" (quilt)
Adult Donor; Falmouth, MA	Fitness Center Mural: Tennis/basketball, Music Therapy Mural: Jazz Ensemble
Adult Donor; Hingham, MA	3-piece ensemble water color: Paintings on Spain

*Frames donated by Hospital trustee, auxiliary, Canteen Committee

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Tufts Health Plan

Health Advocacy Program

Goal: To offer coordinated medical care and social services to seniors who do not regularly visit a primary care physician or who are experiencing stressful social situations, so that they can live with health and dignity in the community.

Target Population: Low-income, underserved elderly residents in Boston's Dorchester community.

Description: Kit Clark Senior Services began the *Health Advocacy Program* in May 1997 with support from Tufts Health Plan's Community Partnerships program. Through the program, Boston's most vulnerable seniors living in its Dorchester community receive coordinated and comprehensive health and social services from both Kit Clark Senior Services (Kit Clark) and Bowdoin Street Health Center (Bowdoin Street). Kit Clark and Bowdoin Street staff are working together as a geriatric team for elders who do not have a primary care physician or whose social conditions adversely affect their health. Kit Clark identified that financial, isolation, cultural and/or linguistic barriers, or an addiction to alcohol or drugs are among the most common and serious social conditions that place many seniors at further risk of deteriorating health.

From December 1996 through March 1997, Tufts Health Plan (Tufts HP) had numerous discussions with Kit Clark to better understand the needs of Dorchester's diverse elderly community, and to develop the *Health Advocacy Program.* These planning sessions resulted in a program that offered the unique combination of serving the community's needs, as well as fulfilling Tufts HP's objective of serving at-risk elders in underserved communities.

The geriatric team, comprised of Bowdoin Street physicians, medical personnel and Kit Clark social service staff, develop individualized care plans for seniors who have been seen by the physicians in Kit Clark's Primary Care Center. This multi-disciplinary team assesses the strengths and needs of each senior in five benchmark areas in order to develop goals to address any problems. They include:

- Medical: annual physical, flu shot, and mammogram or prostate screening
- Functional: education about the benefits of exercise and exercise resources
- Family Formal/Informal Support: identify two emergency contacts and at least two formal or informal community supports
- Home/Living Condition: annual home safety evaluation and appropriate referrals
- Social: at least one out-of-home face-to-face encounter or three in-home encounters

Facilitated by the Health Advocate at Kit Clark, the team routinely explores appropriate interventions in each of these areas. The team also provides support and direct service as needed, provides necessary referrals and transportation to Beth Israel Deaconess Medical Center for other medical care, and records outcomes for the seniors enrolled in the program.

In addition to the measurable benchmark outcomes, the *Health Advocacy Program* brings about another important outcome. A strong collaboration has developed between Kit Clark, Bowdoin Street, Beth Israel Deaconess Medical Center, and Tufts Health Plan.

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UMass Memorial Health Care

Worcester Youth Center Outreach Program

Goal: To address youth empowerment, violence prevention, employment, and increase access to health services, disease and substance abuse prevention, social services, and primary care.

Target Population: Youth ages 14-22 at risk for gang involvement, unemployment, under-education and problems associated with poverty.

Description: The Worcester Youth Center has partnered with UMass Memorial Health Care since its inception in 1994. It provides health care services targeted at improving the health status of Worcester's undeserved youth and is committed to decreasing violence in the community.

Like other urban cities, Worcester is experiencing an increase in violence among racial and ethnic minorities. Gang activity is on the rise. Violence in our city is attributed to poverty, high population density, poor housing conditions, high unemployment rates, and drugs. Decreasing violence and abusive behavior of our youth is an important health care issue. UMass Memorial remains committed to achieving that goal.

Many of the youths served at the Center are involved in negative behaviors such as substance use, violent relationships with peers and intimate partners, and have very low educational attainment. Most of these youth report less than optimal health. Participants range in ages from preteen to early twenties, 85% of all participants are Latino, 60% are male, 23% of all females have one child or more, 60% of the males are teen fathers. While more than 300 youths have received services, 100 youths use the Center on a consistent basis.

UMass Memorial has provided youth with scholarships for programs in the arts, and has donated used furniture, computers, a vehicle and the salary of the Executive Director. The Center for Women and Children has placed a full time Outreach Worker on-site to provide services and help with daily operations. The Center provides a variety of services to youth including on site health care, GED/ESL preparation, substance abuse education and assistance, HIV information, counseling and testing, violence prevention programs, peer leadership training, a job preparedness and skills training program, computer club, and a music program. Last summer, youth from the Center were recruited and professionally trained to perform in a summer theater production of *West Side Story* which was filmed and showcased in the Fall on the TV show *60 Minutes*.

After two years, the Center implemented a wellness program with three components:

- the health clinic

- an "Alternative to Violence" program
- the peer outreach program

The goal of the health service is to set up patients with a primary care physician and remove the cycle of crisis-based or non-existent health care. Individuals without health insurance are assisted with enrollment into publicly funded insurance or covered by UMass Memorial's free care program. Other services include home visiting and outreach services to families, interpreters, court advocacy, mental health counseling and nutrition evaluation.

UMass Memorial and the Center have provided increased employment opportunities. The Youth Center Director and UMass Memorial outreach worker work with young people on interviewing skills, resume creation and work place requirements. Prior to referral for employment the young person is required to provide consistent, dependable volunteer work at the Center. There have been twenty-five successful job placements at UMass Memorial to date which include: dietary, housekeeping, nursing assistants, patient care assistants, business office billing and outreach workers. Most center participants are employed within 6 months of active involvement at the Center.

The Center's director and the UMass Memorial outreach worker have worked actively with the school department and other city agencies to assist young people to get back into school or enroll in GED programs. A GED and ESL program was established on site at the Center in February, 1997. Both programs operate at full capacity. Because of the program's success, the Superintendent of schools approved onsite education indefinitely. The Youth Center is the only school-department-funded site not located on school premises. The percentage of youth not in school or unemployed has declined from 92% to 24% over the past two years.

The population initially attracted to the Youth Center was largely gang-affiliated. 75% of the youth were involved with the juvenile justice system. Rather than rejecting gang affiliations and identities, the Center was designated as "neutral turf," open to all. In order to reach the population and develop trust, the only strict rule established was that all who participate in Center activities treat everyone and the environment with respect. While at the Center, each person enters as an individual, not an extension of his or her gang. Youth who have entered gangs because they perceive this to be their only source of emotional and financial support have returned to the Youth Center stating they are ready to take advantage of what the center has to offer.

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Visiting Nurse Association of Boston

Community Outreach Program

Goal: To provide elders with free health information and services that will help them remain healthy and independent at home.

Target population: Elders with health concerns and questions

Description: The Visiting Nurse Association of Boston's *Community Outreach Program* fills a community health care need by:

- providing free health screenings
- providing free health promotion information in six different languages (English, Spanish, Chinese, Russian, Haitian Creole, and Vietnamese)
- providing free health promotion materials such as wallet cards tracking blood pressure and glucose readings
- facilitating access to quality primary care for those who have no physician of record
- facilitating improved communication with primary care physicians through the use of update cards mailed to physician with patient's latest screening results

The program is a concrete example of the agency's commitment to ensuring access to quality health care. The program's free materials and screenings provide not only a way for these individuals to access information without fear or stigma but also an easy, confidential way to ensure communication with primary care physicians in between office visits.

The Healthy People 2000 report, which represents the input and efforts of over 10,000 people across the nation, outlines specific health goals for the American people to strive for by the year 2000. Fundamental to achieving these goals is the implementation of effective health promotion and disease prevention strategies.[1] Statewide, recent data indicates that nearly 60% of all preventable hospitalizations were for individuals over the age of 64. By comparison, the elderly population accounted for less than 40% of all hospitalizations.[2]

Currently, attendees at VNA of Boston supermarket health screenings range from 50-100 elderly per month; pharmacy clinics average 40-50 participants; senior center screenings average 50-70 attendees; and elder housing complex clinics average 25-50 participants.

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[1] **The Health of Boston 1998:** *A Report on Boston Residents and Neighborhoods*, Boston Public Health Commission, page 7-18

[2] **Preventable Hospitalization in Massachusetts:** *Update for Fiscal Years 1995 and 1996*, Division of Health Care Finance and Policy, Barbara Erban Weinstein, Commissioner, April 1998, p. 11

Community Outreach Nurses have worked collaboratively with both the Joslin Diabetes Center and Brigham and Women's Diabetes Prevention Center to provide diabetes education programs. The *Community Outreach Program* also has established a vital communication link with many area physicians through the use of its mail notification cards. This tool has proved essential to improving communication between patients and physicians in between office visits. At the same time, it has helped patients feel more confident when speaking with their doctors about the conditions the VNAB has helped to monitor.

The largest challenge at the program's inception was getting people to attend the screenings and accept the free services. This involved actively pursuing accessible, highly visible screening sites in the community. Very often, the persistence of VNAB Community Outreach Nurses was essential in securing high visibility sites. Just knowing that the site was desirable was not enough; close collaboration and cultivating a relationship with the management of these sites was essential.

Implementing the program also involved working closely with the local media, social service agencies, physicians, and housing sites to ensure that the program received adequate publicity. The VNAB's Community Relations Department has been successful in implementing a comprehensive outreach plan to publicize the *Community Outreach Program*. This plan has included making posters and handouts available in many languages including English, Spanish, Chinese, Russian, Haitian Creole, and Vietnamese.

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Winchester Hospital Community Health Institute

Putting Prevention Into Practice

Goal: The goal of the program is to assure early detection of treatable health problems. (We believe that the first step in disease management is early detection.)

Target Population: Residents within the Winchester Hospital Service Area

Description: In collaboration with area physicians, the Community Health Institute (CHI) deploys an RN Prevention Specialist to develop a Personal Prevention Plan for each patient in that practice. The plan assures timely physicals as well as screening for cancers (skin, colon, breast, testicular, cervical), hypertension, diabetes, and hypercholesterolemia. The plan also assures timely immunizations and health counseling. The Diabetes Casefinding program served as a springboard for *Putting Prevention Into Practice* (PPP).

The need for these programs was identified after completing the first Health Mapping Report in 1995. Compliance with recommended screenings was well below an acceptable standard. More than 97% have health insurance, yet only 13% have been screened for skin cancer, only 19% have been screened for colorectal cancer, and only 40% have had a mammography. This program makes sense given the numbers who have insurance. When we surveyed the residents in subsidized housing, 100% of them named an area physician as their primary care provider. This being the case, there seemed to be tremendous opportunity to improve the health status of the community by working through the local physicians.

The community partners for this program have been exclusively providers. We recognize this as a deficit in the program and are making plans for establishing a more grass-roots effort. The present collaborators include clinicians at the Winchester Family Physicians practice (4 physicians and 1 nurse practitioner), an internist in Medford, and a rheumatologist in Stoneham.

The impact of the program has been significant. To-date more than 14,000 residents have their own prevention plan. More than 2,000 have reconnected with their physician. New diagnoses made as the result of the program include:

- 142 with hypertension
- 15 with skin cancer
- 361 with hypercholesterolemia
- 58 with diabetes

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Worcester District Medical Society

Worcester Healthcare Outreach

Goal: To link the uninsured with health care.

Target Population: The uninsured, elderly and working poor in the Worcester area.

Description: Worcester Healthcare Outreach (WHO), a project of the Worcester District Medical Society, works aggressively to serve the uninsured and link them to health care opportunities. WHO acts on its cause through several different means:

- Rx Fund: The Rx Fund, created with donations from the business and physicians community, Fallon Healh Care, Tufts Health Plan, SmithKline Beecham, and Astra Pharmaceutical, makes prescription drugs available at no cost to free care eligible patients who cannot afford medication. This program is designed to provide prescription drugs on a short-term basis to uninsured, low-income patients unable to afford medication. Follow-up efforts are made to find long term solutions for patients with chronic needs. Through the program 1500 prescriptions have been filled for 680 people.

- Prescription Access Program: The Prescription Access Program (PAP) is designed to facilitate the ordering of prescriptions from pharmaceutical companies which offer free medication to uninsured, low-income patients.

- Green Island Neighborhood Center Clinic: An evening clinic was established in the Green Island neighborhood – a low income, isolated community – to serve as an access point to channel people into systems of continuous health care. Volunteer physicians were recruited, and a social worker was hired with funds from the Greater Worcester Community Foundation. To date, 1000 people have been treated at the clinic. Green Island serves a large immigrant population from Albania living in the area. The goal is to see patients no more than twice at the clinic, enroll them in one of the health care centers, and help them apply for MassHealth.

- 100% Coverage for Kids: No child in Massachusetts should be without health insurance, yet it is estimated that 10% of children in the Commonwealth have no coverage. WHO has embarked on a campaign through the schools to enroll children in MassHealth or the Children's Medical Security Plan. In a pilot program at one school, a well-developed plan was implemented consisting of notices to families, phone calls, follow-up appointments, etc. The goal of 100% was achieved. Also, a project was implemented to enroll children in insurance programs during public school registration, and "know-your-school" programs.

- Free Specialty Care: Uninsured patients, who are ineligible for MassHealth – with incomes at or below 200% of poverty – are entitled to free care at area hospitals. These same patients, however, were receiving bills from physicians associated with the hospitals. WHO recruited over 200 physicians who agreed to treat these patients and waive the expense. WHO assumed the responsibility of referring all of the free care patients at Great Brook Valley Health Center to volunteer specialists. Volunteer specialists were also found for free care patients referred by

Family Health & Social Service Center and walk-in-clinics. Three hundred and fifty referrals were made in the past two years. This program is now system wide at UMass Memorial with over 8000 physicians participating. Individual physicians from St. Vincent Hospital are also part of the program.

- Interpreter Services: Worcester Healthcare Outreach recruited volunteer physicians to treat low income, uninsured patients and waive fees. When the patient was non-English speaking and the visit took place in a private office, as opposed to a hospital or clinic setting, interpreters were sent and paid for by WHO. The goal was to assure a successful visit, and reduce one of the chief barriers to quality care. Also, the expectation was that physicians would learn to appreciate the value of a trained interpreter. In the past two years, we have arranged for 150 interpreters at medical encounters. A questionnaire to physicians identifying barriers to delivering quality care listed language barriers as a major problem.

- WHO Health Line: An aggressive outreach program has been launched. Fliers and posters are displayed throughout the city; signs are posted on Worcester buses; public service announcements urge the uninsured to call our health line. To date, over 2500 referrals have been made. Assistance is provided to callers in need of information concerning insurance, the free care pool, immunization services, and other health-related programs.

- Enrolling uninsured in community health centers: A major goal of WHO is to increase awareness of primary care offered free or on a sliding scale at Great Brook Valley Health Center, Hahnemann Family Health Center, Family Health of Worcester, Lincoln Primary Care, and Plumley Village Health Center. Uninsured callers to our health line and patients who visit the free care clinics are regularly linked to the health care centers.

These programs could open the door to thousands of patients who otherwise could not secure necessary health care. Worcester Healthcare Outreach supports three walk-in clinics (one of which was created by Worcester Healthcare Outreach) which treat over 5,000 patients per year. WHO is a Robert Wood Johnson Foundation funded project (WHO), in partnership with the Massachusetts Medical Society and Central Mass. Area Health Education Center.

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